SOCIAL DISTANCING BETWEEN NURSE AND PATIENT

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ABSTRACT

This thesis accepts the claim of theories of knowledge which presuppose a non-cognitive principle, such as Derrida´s *différance*, as the condition of interpreting the person´s recognition of objects in the world. In non-cognitive theories, the person´s recognition of objects is uncertain. This position is opposed to theories of knowledge which presuppose a cognitive principle, such as the *ego* of Descartes, and which claim that a correspondence between person and object is certain.

The major aim of this thesis is to show how the nurse´s certainty about a correspondence excludes the patient´s recognition from her recognition. The effect is the creation of a social distance between nurse and patient. Another aim is to show how the nurse´s uncertainty about a correspondence allows nurse and patient to exchange their recognitions. Such exchange, understood as the possibility of accomplishing a kind of correspondence, decreases a social distance between nurse and patient.

Achieving these aims involves an explication of how nursing theorists interpret the nurse´s recognition. For instance, Orlando´s (1961) idea of "exploration" is analysed to be a non-cognitive and a minimal cognitive interpretation of the nurse´s recognition.

I draw on Johnson´s (1974) work to elucidate how the development of conceptions of nursing imply a cognitive interpretation of the nurse´s recognition. I then exemplify how the nurse´s recognition when based on Abdellah´s (1960) or Roy´s (1984) conceptions of nursing of ´the whole patient´ is not corresponding with ´the whole patient´.

Finally, I examine the work of Benner et al (1996). I discuss the difference between the principles Benner et al and Dreyfus and Dreyfus (1996) presuppose in order to explain the nurse´s skill acquisition as a move through stages from novice or advanced beginner to competency and then to proficiency and expertise.

This discussion entails an analysis of the cognitive principle of Benner et al (1996). In turn, I explicate how the nurse´s certainty of her recognition informed by her practical knowledge to correspond with the situation of the patient at the proficient and expert stage excludes the patient´s recognition from her recognition.

DECLARATION

I declare that this thesis has been composed by myself and the research reported in it is my own work.

Signed:

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PROLOGUE

Concerning the reception of *From Novice to Expert,* Benner et al state in *Expertise in Nursing Practice* that: "Nurses commented that *From Novice to Expert* put into words *what they had always known about their clinical nursing expertise,* but had difficulty articulating" (1996:XIII; emphasis mine).

Reading those statements about three years ago, I was reminded of my own response to *From Novice to Expert*. My experience as a nurse, that is, of having seen many patients with similar diseases in everyday work on the ward, accounted, there was no doubt in my mind, for being able to recognize what was going on with the patient. Moreover, I had found it rather easy to convey to the patient and others, for example, student nurses as well as physicians, that my recognition, even though it could not always be supported with ´numbers and micrograms´, was a certain grasp of the patient´s problem. Considering *From Novice to Expert* to be a study which postulates this view of recognition, indeed ´put into words what I had always known´.

Yet when I first read *From Novice to Expert* - way back in the middle of the eighties - I was not any longer nursing, but head of an institution that educates nurses as well as nurse teachers. Being a ´head´ meant that I was not any more engaged in clinical as opposed to classroom teaching; and it seemed to me, at the time, that the further I had gotten myself away from the patient, the more demanding it had become to convey, especially to student nurses, the ´ability´ to see the patient´s problem, which I considered to be the very essence of nursing. In this way, *From Novice to Expert* promised to be a helpful teaching tool.

On the other hand, I had been alerted by Benner´s definition of recognition, such as: "Experience, as it is used here (Heidegger, 1962; Gadamer, 1970), results when preconceived notions and expectations are challenged, refined, or disconfirmed by the actual situation"

(1984:3). Or, "Heidegger (1962) and Gadamer (1975) define experience as the turning around of preconceptions that are not confirmed by the actual situation" (1984:8).

Knowing very well that the knowledge ("preconceptions") passed on to student nurses in the classroom is, primarily, of a general kind, and knowing equally well that student nurses, the moment they enter the ward, face up to the "actual" situation, that is, the particular patient, I thought that Heidegger and Gadamer, as presented by Benner, were giving an answer to this conflict between the 'general' and the 'particular' as encountered by nurses in their everyday work in that the latter: particular patient - does not confirm the former: the nurse's general knowledge. Putting it in another way, Benner's quotes, cited above, constitute the claim that the nurse's recognition of the patient as based on her knowledge ("preconceptions") is, according to Heidegger and Gadamer, *uncertain*.

But Benner not only claims, following Heidegger and Gadamer, that the nurse's recognition is uncertain. She also derives the claim about the nurse's *certain* recognition from them. Because Benner writes that: "Experience" (the nurse's recognition as based on her "preconceptions" not being confirmed by the particular patient) "is *therefore* a requisite for *expertise*" (1984:3; emphasis mine). Saying it differently, the nurse's 'unconfirmed' recognitions of the particular patient in her everyday work are considered to be a necessity of acquiring "expertise". Which means that Benner bases the nurse's development of her recognition in terms of stages from novice to "expertise", that is, the Dreyfus Model of skill acquisition, on Heidegger and Gadamer.

By the time the nurse gets to the stage of expertise she has developed, Benner claims, an "intuitive" recognition. This "intuitive" recognition of the nurse at the expert stage "zeroes in", according to Benner, "on the *accurate* region" of the patient's problem (1984:32; emphasis mine); the expert nurse's "intuitive" recognition is, for Benner,

following Heidegger and Gadamer, an 'accurate', that is, a certain grasp of the particular patient's problem.

Yet, I wondered, how Benner (1984) could draw on Heidegger and Gadamer for both: an understanding of the nurse's perception as uncertain as well as certain. In other words, *From Novice to Expert* is lacking an explicit discussion of the theory underpinning the Dreyfus Model of skill acquisition. Telling the reader that it is based upon the study of "chess players and airline pilots", Benner (1984) is not saying much about the theoretical basis of those studies.

At the time of my first encounter with *From Novice to Expert,* I did not have the resources to further investigate this lack of explanation. I began my inquiry only a number of years later in the context of my doctoral studies. In the course of this endeavour I found out that I was not the only one to miss a theoretical explanation of the nurse's acquisition of an "intuitive" grasp in *From Novice to Expert*. English points out that Benner's (1984) notion of intuition "as a concept" is "somewhat ambiguous" (1993:387). It "merely provokes", in his opinion, "further investigation" (English, 1993:390).

English's claim that Benner's intuition needs "further" study is implicitly endorsed by Darbyshire (1994). In his response to English's (1993) critique, Darbyshire makes reference to the work of authors other than Benner (1984), for example, Dreyfus and Dreyfus (1987) or Dreyfus (1992), in order to elucidate his assertion that "Benner's work" is developed from Heidegger's "phenomenological" understanding.

That the work of Benner (1984) is based on Heidegger is also the opinion of Cash (1995). He states that Benner "has applied" Heidegger's theoretical perspective as interpreted by Dreyfus (1991) "in the context of *expertise*" (Cash, 1995:527; emphasis mine). *Nota bene,* neither Darbyshire nor Cash refer to Gadamer and how his specific perspective on recognition underlies Benner's notion of the Dreyfus Model of skill acquisition.

But, more importantly, the possibility of founding the Dreyfus Model, understood as the nurse´s acquisition of a certain ("intuitive") recognition of the particular patient by the time she gets to the expert stage, on Heidegger or Gadamer is challenged by Latimer (1993). She describes Benner´s idea of the nurse´s skill acquisition as a transformation of the nurse´s "knowing that" into "know how". In Latimer´s words: "Benner claims that ´know how´ (for example, the qualitative difference in pulse or the meaning of numbers) gained through experience and acting in the world, transforms ´knowing that´" (1993:312). She continues:

> The difficulty here is that Benner´s claims to draw on Heidegger (1962) and Gadamer (1976) are questionable since ...´sequence´ (is) problematised by them (Latimer, 1993:312).

Recalling that I had been wondering (see above) how Benner (1984) could define the nurse´s recognition, following Heidegger and Gadamer, to be uncertain and to be certain, Latimer suggested an answer. Heidegger and Gadamer problematize, according to her, "sequence"; that is, the nurse´s *acquisition* of a certain ("intuitive") recognition in terms of stages from novice to expert. If so, Heidegger´s and Gadamer´s views on recognition, as defined by Benner (1984), question Benner´s (1984) claim about the nurse´s certain ("intuitive") perception at the expert stage.

Accepting Latimer´s position as a correct rendering of Heidegger and Gadamer, and accepting, on the other hand, that Benner´s definition of an uncertain recognition offers also a correct reading of these theorists, then, in order to validate both positions, it should be possible, I concluded, to show in connection with the nurses´ accounts in *From Novice to Expert* the following: how Heidegger´s and Gadamer´s theories of recognition undermine the Dreyfus Model of skill acquisition. In more detail, how the particular patient does not confirm the nurse´s recognition and that this is the case whether the nurse is

considered by Benner to be at the stage of novice, advanced beginner, competent, proficient or expert.

But such study was unrealistic, since Benner presents in *From Novice to Expert* accounts of nurses from the stages of novice *and* expert, but not from the 'between' stages: advanced beginner, competency and proficiency. Fortunately, Benner et al (1996) report in *Expertise in Nursing Practice* a study of the nurse's skill acquisition which provides nurses' accounts from the stage of advanced beginner *through* to the expert stage.

Nonetheless, explicating - on the basis of these accounts in *Expertise in Nursing Practice* - how Benner's (1984) view of an uncertain recognition (following Heidegger and Gadamer) challenges Benner's (1984) claim about a certain ("intuitive") recognition of the nurse at the expert stage (following the Dreyfus Model), did not prove to be straight forward. The reason being that Benner's theoretical explanation of the Dreyfus Model of skill acquisition in *From Novice to Expert* - as I have discussed above - differs from the explanation Dreyfus and Dreyfus (1996) and Benner et al (1996) give of the nurse's skill acquisition in *Expertise in Nursing Practice*. These are the main points of difference:

Firstly, Dreyfus and Dreyfus explain in *Expertise in Nursing Practice* the nurse's skill acquisition from novice to expert on the basis of the nurse's physiological brain processes (Chapter Four in the thesis). This explanation is in contrast to Benner's (1984) which derives the Dreyfus Model of skill acquisition from Heidegger and Gadamer. (It also contrasts with Darbyshire and Cash who consider Benner's study in *From Novice to Expert* to be based on Heidegger).

Secondly, Benner et al (1996) conceive in *Expertise in Nursing Practice* the nurse's skill acquisition from the stage of advanced beginner to expert in terms of the nurse's development of "skills of seeing" and practical knowledge *as well as* in terms of the nurse's development of a mutuality of practical knowledge and emotions

(Chapters Six and Seven in the thesis). This conception of the nurse´s skill acquisition adopts the explanation of Dreyfus and Dreyfus (1996) in a particular way (which I will explain further below) and is, therefore, at variance with Benner´s (1984) (see first point).

Thirdly, Benner et al (1996) consider, on their understanding of a "Cartesian view", the advanced beginner nurse´s recognition to be uncertain in the sense of being "objective, disengaged, criterial" (Chapter Four in the thesis). Grounding the claim about the nurse´s uncertain recognition on their rendering of a "Cartesian view" opposes, however, Benner´s (1984) definition of an uncertain recognition which is derived from Heidegger and Gadamer.

Fourthly, Dreyfus and Dreyfus (1996) develop, following Heidegger, the notion of caring and differentiate the nurse´s caring from her bearing "the science and technology of medicine on a specific body with a specific disease" (1996:47). Benner et al (Chapter Nine in the thesis), who specifically refer to the discussion of Dreyfus and Dreyfus in *Expertise in Nursing Practice*, distinguish "theoretically" between "medical and nursing theory related to science and existential caring skills" (1996:160).

Benner et al claim, on the other hand, that the nurse at the proficient and expert stage reveals two recognitions: "skills of seeing" based on her practical knowledge *and* "caring practices" (with the former the nurse perceives the ´body´, with the latter the "concerns" of the patient). Benner et al´s claim in *Expertise in Nursing Practice* about the nurse´s acquisition of *two* certain recognitions in terms of stages from advanced beginner to expertise is in contrast to Benner´s claim in *From Novice to Expert* that the nurse acquires *one* certain ("intuitive") recognition.
Moreover, while Benner (1984) associates Heidegger and Gadamer with the notion of a move ("sequence", Latimer, 1993) concerning the nurse´s recognition from the stage of novice (uncertain) to expert (certain); Benner et al

(1996) relate Heidegger and the notion of move with the nurse´s recognition as "caring practices" at the proficient and expert stage which implies that the nurse at the (novice) advanced beginner and competent stage apparently lacks such ´caring´ recognition.

These five points indicate the major differences between *Expertise in Nursing Practice* and *From Novice to Expert* with regard to the theoretical conception of the Dreyfus Model. But there is also a disagreement to be found within *Expertise in Nursing Practice*: between Dreyfus and Dreyfus, who explain the nurse´s skill acquisition in terms of stages on the basis of *physiological* brain processes and Benner et al, who study the nurse´s skill acquisition in relation with *cognitive accounts* of the nurse´s ´brain processes´ (Chapter Four in the thesis).

This disagreement and the differences listed before, in short, these inconsistencies, could, however, not be named in advance of the study. While I had hunches and insights of inconsistencies, taking them together did not add up to more than a puzzle. Yet it was necessary to find a way out of this confusion, if I wanted to pursue my project: to show how Heidegger´s and Gadamer´s perspective on recognition (uncertain) as presented by Benner (1984) undermines her claim and that of Benner et al (1996) about the nurse´s certain recognition at the proficient and expert stage on the basis of their conception of the Dreyfus Model of skill acquisition.

Finding this way proved to be complicated, since Benner et al associate theoretical knowledge, the kind of knowledge advanced beginner nurses´ learn in nursing school, with a "Cartesian view", and - on the other hand - "skills of seeing" and practical knowledge as well as "caring practices" with the Dreyfus Model of skill acquisition. This link between a particular kind of knowledge and a particular conception of knowledge implies that Benner et al take theories of knowledge to be descriptions of the person´s recognition (Chapter Five in the thesis).

This understanding opposes a view that these theories are interpretations of the person´s recognition which raise distinct claims. For example, a "Cartesian view" asserts that recognition is certain; and Heidegger´s theory postulates that recognition is uncertain.

However, conceiving theories of knowledge to be descriptions (rather than interpretations), as Benner et al do, and connecting such notion with the Dreyfus model of skill acquisition, inverts these claims: a "Cartesian view" describes, for them, the advanced beginner nurse´s recognition as informed by her theoretical knowledge to be uncertain; and Heidegger´s theory denotes, for them, the expert nurse´s recognition in terms of "caring practices" to be certain.

In order to be able to redress Benner et al´s conception about theories of knowledge (being descriptions and relating them to the Dreyfus Model which entails the inversion of claims), I have adopted the position that there is a move in theorizing (interpreting) recognition from ´certainty´ to ´uncertainty´ - rather than a move with regard to the nurse´s uncertain recognition as based on her theoretical knowledge at the (novice) advanced beginner stage to her certain recognition at the stage of proficiency and expertise in terms of "caring practices" as well as "skills of seeing" and practical knowledge.

This move in theorizing is hinted at by Benner and Wrubel (1989) in *Primacy of Caring*. The authors write that "Husserl´s *noema* (an abstract mental structure that accounts for the mind´s directedness toward objects) is a *cognitive,* representational view of the mind" which they distinguish from Heidegger´s view (1989:42; emphasis mine).

Benner and Wrubel are implying here that Heidegger does not any longer have a "cognitive" view, that is, a conception as the condition of interpreting recognition (the "directedness" of a person´s mind "toward objects") like Husserl. And because Heidegger no longer conceptualizes the condition of his interpretation, that

is, because of his non-cognitive view, he has 'lost' the basis upon which he could assert that the person's perception is certain. But it is important to keep in mind here that this 'loss' means for Benner and her colleagues a certain recognition.

Adopting the position that theories of knowledge are interpretations of recognition and that they have moved from a cognitive to non-cognitive stance, and that Heidegger's as well as Gadamer's theory are an example of the latter, but taking into account that Benner (1984) and Benner et al (1996) are calling upon them - especially on Heidegger - in contrasting ways (as mentioned in relation with the inconsistencies above), I have decided to discuss their non-cognitive views with another theorist, namely, Derrida.

That is, my study of Benner et al's research in *Expertise in Nursing Practice* accepts the claim of theories of knowledge which presuppose a cognitive principle, such as the *ego* of Descartes, that a correspondence between person and object is certain. This position is opposed to theories of knowledge which presuppose a non-cognitive principle, such as Derrida's *différance*, as the condition of interpreting the person's perception of objects in the world. In non-cognitive theories, the person's recognition of objects is uncertain.

My main aim was to show how the nurse's certainty about a correspondence excludes the patient's recognition from her recognition. The effect is the creation of a social distance between nurse and patient. Another aim was to show how the nurse's uncertainty about a correspondence allows nurse and patient to exchange their recognitions. Such exchange, understood as the possibility of accomplishing a kind of correspondence, decreases a social distance between nurse and patient.

Approaching Benner et al's study in *Expertise in Nursing Practice* in terms of two claims derived from two different theoretical positions (a cognitive and a non-cognitive interpretation of recognition) allowed me,

firstly, to make the inconsistencies referred to earlier apparent *in the process* of accomplishing the aims of the study; that is, leading in an unobtrusive way out of the confusion characterizing Benner´s (1984) and Benner et al´s theoretical discussion of the Dreyfus Model.

This approach to Benner et al´s research allowed me, secondly, to include conceptions of nursing like Orlando´s (1961), Johnson´s (1959a), Abdellah´s (1960) and Roy´s (1984) in the analysis of Benner et al´s research in *Expertise and Nursing Practice* and thus place the study in the wider context of nursing theory; in particular within that substantive tradition which seeks to develop a science of nursing on the basis of conceptions of nursing (Chapter Two and Three in the thesis).

Including conceptions of nursing in the thesis entailed, however, a special demand in as far as authors like Orlando, Johnson, Abdellah and Roy do not explicitly address matters of epistemology - in contrast to Benner et al.

This demand and the fact that the approach to the study on the basis of two claims each presenting different theoretical positions (a cognitive and a non-cognitive interpretation of recognition) had come about in order to overcome Benner et al´s notion of those interpretations being descriptions and the consequences following from it as I have indicated above, determined the way of outlining the argument of the thesis as presented in the Introduction.

CHAPTER ONE

INTRODUCTION

From Novice to Expert: Excellence and Power in Clinical Nursing Practice is the book in which Benner (1984) reports her study of how nurses develop practical knowledge in everyday work. Benner asserts that the nurses´ development of practical knowledge moves in stages. Following the concept of skill acquisition of Dreyfus and Dreyfus, Benner identifies these stages as - novice, advanced beginner, competency, proficiency, and expertise.

The study of Benner (1984) about the development of practical knowledge received, according to Benner et al (1996), a worldwide response from nurses. They write:

> No one could have predicted the response of practicing nurses all over the world to that account of gaining clinical expertise, ... *From Novice to Expert* has been translated into Finnish, German, Japanese, Spanish, French and Swedish, and a limited number of copies were translated for Russian nurse educators. It has been the source of many conferences and nursing curricula, and the basis for clinical promotion programs in many hospitals in many parts of the world (Benner et al, 1996:XIII).

The translation of *From Novice to Expert* from English into more than six languages and its international utilization for the education of nurses indicates an impressive reception of Benner´s research by members of the profession. Benner obviously succeeded in expressing how nurses who are involved in the day to day care of patients think about the knowledge they gain through their work with them. Because Benner et al (1996) note: "Nurses commented that *From Novice to Expert* put into words what they had always known about their clinical nursing expertise, but had difficulty articulating" (1996:XIII).

With *Expertise in Nursing Practice* Benner et al (1996) present an extension of the research begun in *From Novice to Expert*. In this second study, Benner et al postulate that the nurse´s recognition of the situation of the patient at the advanced beginner stage is based on theoretical knowledge, that is, the kind of knowledge nurses learn in nursing school.

Recognizing the situation of the patient in terms of theoretical knowledge is, for Benner et al, putting a "preconceived set of expectations" over the situation (1996:142). More specifically, their claim is that the theoretical knowledge informing the advanced beginner nurse´s recognition fails to correspond with the situation of the patient.

The nurse´s recognition informed by her theoretical knowledge at the advanced beginner stage is seen to differ sharply from the nurse´s recognition once she has moved to the stages of proficiency and expertise. By then, the nurse has, in the opinion of Benner et al, gained enough "skills of seeing" and practical knowledge through her everyday work with a particular group of patients which enables her to "read" the situation of the patient.

Reading the situation of the patient in terms of her "skills of seeing" and practical knowledge is, for Benner et al, not any longer laying theoretical knowledge ("preconceived set of expectations") over the situation characteristic of the advanced beginner nurse. Stating that the nurse´s recognition informed by her "skills of seeing" and practical knowledge is *reading* the situation of the patient "instead" of putting theoretical knowledge over the situation in the sense that the advanced beginner nurse´s recognition is not corresponding with the situation, Benner et al are saying that the nurse´s recognition at the proficient and expert stage *is* corresponding with the situation of the patient.

To reiterate, then, the assertion of Benner et al is twofold. First, they assert that the nurse´s recognition at the proficient and expert stage is corresponding with

the situation of the patient *because* it is based on "skills of seeing" and practical knowledge acquired in everyday work. Second, they assert that the nurse´s recognition at the advanced beginner stage is not corresponding with it *because* it is based on theoretical knowledge from nursing school.

This dual assertion stands in stark contrast to the claim, advanced in this thesis, that the nurse´s recognition whether informed by her theoretical knowledge learned in nursing school or by her "skills of seeing" and practical knowledge acquired in everyday work is *not* corresponding with the situation of the patient. Moreover, it is argued that the certainty imputed to any such correspondence is the condition of possibility for creating a social distance between nurse and patient in everyday work.

These arguments of the thesis are in obvious contrast to those made by Benner et al (1996). In order to elucidate them further, it is necessary to discuss the condition of possibility and impossibility of the claim about a correspondence between the nurse´s recognition and the situation of the patient.

Theories of Knowledge with a Cognitive Principle

In the tradition from Plato to the present, theories of knowledge posit a cognitive principle, such as the *ego* of Descartes, as the condition of interpreting the person´s recognition of objects in the world. For reasons which will be discussed below, this tradition has been named ´logocentric´ by Derrida. From the logocentric point of view, the object to be recognized is first the object of a cognitive principle which constitutes the existence and the knowledge of the object.

Theories of knowledge with a rational precondition claim that there is a correspondence between person and object. For example in scientific work, knowledge of the object is accepted as certain only if the correspondence between predetermined principles and the object under

consideration can be verified. It means also that the certainty of the person´s knowledge in everyday practice depends on the correspondence between his or her knowledge and the object recognized.

The claim of logocentrism (theories of knowledge with a cognitive principle) about a correspondence between recognizing person and object recognized is, as Derrida reveals, implicit in the presuppositions of its claim. Saying this in another way, the presuppositions of logocentrism are the condition of possibility of asserting a correspondence between person and object.

One of the presuppositions logocentrism holds to is the idea of being able to formulate the condition that explains the person´s recognition as corresponding with the object. But this very idea exists only, on the analysis of Derrida, through the condition logocentrism establishes in terms of cognitive principles, such as *ego*, *telos*, or *consciousness*, to make such demand. That is, a thought in the cognitive principle allows itself to be precomprehended in terms of identifiable categories, while the possibility of a thought in the cognitive principle is "itself only through the logos; that is, *being nothing* before the logos and outside of it" (Derrida, 1976:20; emphasis in the original).

Another presupposition which is closely related to the one just stated is the notion that the object gets naturally translated to the mind. Derrida captures this assumption:

> Between being and mind, things and feelings, there would be a relationship of translation or natural signification; between mind and logos, a relationship of conventional symbolization (1976:11).

Here, the idea of the mind grasping the object ("natural signification") meets with the presupposition of logocentrism. The presupposition is that grounding knowledge of the object in the mind and, therefore, in a cognitive principle ("conventional symbolization") can be achieved.

A third presupposition of logocentrism which Derrida uncovers concerns the notion of a natural correspondence between mind (cognitive principle) and voice, because of the nearness of thought to sound:

> the essence of the *phonè* would be immediately proximate to that which within 'thought' as logos relates to 'meaning', produces it, receives it, speaks it, 'composes' it (Derrida, 1976:11).

The traditional assumption is that the voice "signifies 'mental experiences' which themselves reflect or mirror things by natural resemblance" (Derrida, 1976:11). The spoken word becomes, then, in the logocentric tradition the "first" signifier of the mind (cognitive principle) which itself resembles the object by natural signification.

Since the way of signification is assumed to be from object to mind (cognitive principle) and then to voice, the voice is considered to produce "the first symbols"; it has a relationship of "essential and immediate proximity with the mind" (Derrida, 1976:11). The spoken word (sound) is for logocentrism the "nonexterior, nonmundane therefore nonempirical or noncontingent" signifier (Derrida, 1976:7-8) of a primary signified, the mind (cognitive principle).

In the context of elucidating that these presuppositions of theories of knowledge with a cognitive principle (logocentrism) are the condition of possibility of claiming a correspondence between person and object, Derrida turns to linguistics, in particular to the linguistics of Saussure, in order to show that they are also the condition of impossibility of raising such claim.

I now turn to present Saussure's (1960) thesis of the arbitrariness of the sign and the thesis of difference. The point of presenting these twin theses is to indicate how Derrida (1982), in radicalizing these theses, conceptualizes a non-cognitive principle, *différance*, as

the condition of interpreting the person's recognition of objects in the world.

Saussure's Theses

Saussure distinguishes between speech (*la parole*), the spoken word and the system of its form which he calls *la langue*. The latter is the cognitive principle according to which the words of languages are structured in such a way that they can be recognized and controlled as the components of a particular type of language, for example, of English rather than of French.

This structuring involves differentiating and associating words in terms of a linguistic sign which itself is not manifest. Such a sign consists of a sound image and a concept (Saussure, 1960:66). These two elements of the sign become intimately united, whereby each is seen to recall the other. This linking of sound and concept is not, however, straightforward, as Saussure explains.

The way concept and sound image recall each other is, according to Saussure, "arbitrary" (1960:67). The arbitrary bond between concept and sound image of the sign becomes apparent when one thinks of the difficulty a person has when repeating the same succession of sounds of a particular word a second time; which is to say, that thought and sound are not linked by a natural relationship. For Saussure, there exist "neither ideas nor sounds" before speech (1960:120).

Rather, the unity of the sign: sound image and concept recalling each other, is considered to effect, at the same time, thought (signified) and sound (signifier). The thesis that the sign is arbitrary (thought and sound unite *in* speech) breaks with the presupposition of logocentrism that the spoken word (sound) is the signifier of a primary signified (cognitive principle); that there is thought *before* sound.
Any sign, understood as the unity of concept and sound image, implies, for Saussure, difference. A sign can be

differentiated from another sign when its sound image can be differentiated from that of another sign. The sound image can be differentiated from another sound image (and thus a sign from another sign), when the sound image combines with a concept. This combination is effected by the system of *la langue*. So Saussure can write that the combination of sound image and concept "produces a form, not substance"(Saussure, 1960:113).

Language as a system of differences has no substance. It is not a repository of *positive* signs that exist prior to its linguistic system (*la langue*). In language, Saussure claims, "there are only differences *without positive terms*" (Saussure, 1960:120; emphasis in the original). A term is seen to derive its "value" only from what it is *not* with respect to other terms: "The idea or phonic substance that a sign contains is of less importance than the other signs that surround it" (Saussure, 1960:120).

A Non-cognitive Principle

Derrida, who is interested to show how a cognitive principle which logocentrism presupposes as the condition of possibility of claiming a correspondence between person and object is also its condition of impossibility, teases out the consequences of Saussure´s thesis of the arbitrariness of the sign and the thesis of difference.

One consequence is, according to Derrida, that even the sign itself is not corresponding with itself: "the signified concept is never present in and of itself, in a sufficient presence that would refer only to itself" (1982:11). This ´being not present to itself´ of a concept comes about, because every concept is seen to be inscribed "in a system within which it refers to another concept by means of the *systematic play of differences*" (Derrida, 1982:11; emphasis mine).
The upshot of a "systematic play of differences" is that the condition of how the concept becomes inscribed in a system cannot be thought any more. Derrida captures this impossibility with the artifical term of *différance*.

This term of *différance* is derived from the French verb *différer* which carries two senses. One is to put a distance between two conditions of the same thing (to delay, but also in the sense of to defer), the other is to differ. In *différance* both senses are thought together (Derrida, 1982).

In particular, the interval (distance) that separates one concept from the other and thus determines it is, at the same time, the deferral of "presence", on the 'basis' of which the concept is not corresponding with itself. In this way is *différance* "no longer simply a concept", but a "possibility of conceptuality" (Derrida, 1982:11). *Différance* conceptualizes, for Derrida, the impossibility of formulating the condition of interpreting the person's recognition.

Différance, understood in this way, is a non-cognitive principle and implies that the claim about a correspondence between person and object 'based' on such non-cognitive principle cannot be considered to be certain, since the condition of such possibility (claim), a cognitive principle, is not any longer presupposed. To the contrary, it can be assumed to have been revealed as an impossibility.

Two Claims Illustrated

The above account allows to conclude that theorizing the person's recognition of objects in the world has moved from theories of knowledge presupposing a cognitive principle, for example, the *ego* of Descartes, to those positing a non-cognitive principle, for example, Derrida's *différance*.

Theories of knowledge with a cognitive principle (in short, cognitive theories of knowlege) claim a correspondence between person and object upon such rational precondition to be possible and, therefore, to be *certain*. This claim of cognitive theories of knowledge is

stated, I suggest, by Benner et al in *Expertise in Nursing Practice*. They write: "The common sense of our discipline", that is, the discipline of nursing, "and of the Western tradition is that in order to perceive and relate to things, we have some content in our minds that *corresponds* to our knowledge of them" (Benner et al, 1996:8; emphasis mine). That is, the person's, for example, the nurse's recognition as informed by the knowledge she has in her mind of "things", such as, the situation of the patient, is by the Western tradition and the nursing discipline assumed to correspond with the situation of the patient recognized.

Theories with a non-cognitive principle (in short, non-cognitive theories of knowledge) assume to have revealed that such rational precondition is an impossibility and claim, thus, a correspondence between person and object to be *uncertain*.

The following example can help to bring out the claims as raised by a cognitive and a non-cognitive interpretation of recognition:

> Three times, a nurse saw a patient lifting his right leg up into the air and down again. Approximately half an hour later the nurse saw this identical behaviour repeated. The nurse asked, "For the past half hour you look as though you've been exercising your leg. Have you?" The patient replied, gritting his teeth, "No, nurse, it just helps a little. I have a sharp pain in my back and it's killing me" (in Orlando, 1961:38).

This nurse tells the patient about her recognition of his situation as if the patient had been "exercising" his leg for the "past half hour". But the patient is not confirming the nurse's recognition. He says "No, nurse" and tells her about his back pain and that 'exercising' his leg helps him a bit to ease his pain. The patient discloses to the nurse that her recognition is not corresponding with his recognition of his situation.

From the view of a cognitive theory of knowledge, the nurse´s recognition informed by her knowledge establishes a correspondence with the situation of the patient ("For the past half hour you look as though you´ve been exercising your leg").

The nurse who holds to a cognitive interpretation of her recognition can assume to be certain that her observation of the patient "exercising" his leg for the "past half hour" is corresponding with the situation of the patient, that is, "exercising" his leg for the "past half hour". After all, she has seen the performance of the patient at least "three times".

From the view of a non-cognitive theory of knowledge, the nurse´s recognition informed by her knowledge is claimed to establish a correspondence with the situation of the patient ("For the past half hour you look as though you´ve been exercising your leg") and to produce, at the same time, the recognition of the patient of his situation ("No, nurse, it just helps a little. I have a sharp pain in my back and it´s killing me"). The patient´s recognition is considered to be effected *through* the nurse´s recognition.

This can be underlined, if one considers that the nurse could have made another observation. Supposing, for a moment, she would have said ´I see you are having those pains in your leg again, because you are exercising your leg´, this patient would very likely have answered ´No, nurse, it´s my back this time and exercising my leg does help a little, it´s killing me´ rather than: "No, nurse, it just helps a little. I have a sharp pain in my back and it´s killing me".

The nurse´s recognition produces, in achieving a correspondence with the situation of the patient, the recognition of the patient in relation to it. As an effect of the nurse´s recognition, the patient´s recognition of his situation is absent from the nurse´s recognition of the situation of the patient. The nurse *cannot* assume to

know the recognition the patient has of his situation which she produces through her recognition.

A nurse who adopts a non-cognitive interpretation of her recognition will, therefore, be uncertain about a correspondence between her recognition and the situation of the patient. The nurse in the example illustrates the point. She leaves her statement about the patient "exercising" his leg for the "past half hour" open by asking the patient "Have you?"

Since the patient answered her question, the exchange of recognitions between nurse and patient about the situation of the patient indicates that such exchange would be the condition of possibility of accomplishing a kind of correspondence between nurse and patient about the situation of the patient in everyday work.

A non-cognitive interpretation of recognition reveals, on the other hand, how the nurse who is certain that her recognition corresponds with the situation of the patient excludes the patient´s recognition of his situation (which she produced through her recognition in the first place) *from* her recognition. This exclusion of the patient´s recognition of his situation from the nurse´s recognition of it as effected through her certainty *is* the social distance the nurse creates between herself and the patient.

Repeating the Claim of a Cognitive Interpretation

Theories of knowledge which have a cognitive principle as the condition of interpreting the person´s recognition, I have outlined above, claim that a correspondence between the nurse´s recognition and the situation of the patient is certain.

This view contradicts Benner et al (1996) who assert that the nurse´s recognition at the proficient and expert stage corresponds with the situation of the patient *because* it is informed by her "skills of seeing" and practical

knowledge instead of her theoretical knowledge from nursing school. Benner et al are of the opinion that the certainty about a correspondence depends on the *kind* of knowledge the nurse develops in her everyday work with a particular group of patients.

This opinion of Benner et al can be highlighted with the following quote by Benner and Wrubel (1989) which is based on Benner's (1984) study *From Novice to Expert*. They write:

> Nursing theorists have been overly constrained by the stringent requirements of the received view of formal theories and have found it difficult to capture the embodied, relational, configurational, skillful, meaningful, and contextual human issues *that are central to expert nursing care* (Benner 1984) (Benner and Wrubel, 1989:6; emphasis mine).

Benner and Wrubel are implying here that the nurse's recognition informed by conceptions of nursing (theoretical knowledge) of nursing theorists who are, according to Benner and Wrubel, "constrained" by the "received view of formal theories" is not capturing, that is, not corresponding with the various "human issues" in the situation of the patient.

Noting, however, that various "human issues" are important to the care of patients by nurses at the expert stage ("central to expert care"), Benner and Wrubel are saying that the nurse's recognition at the expert stage, since it is informed by practical knowledge is picking up those various "human issues" and is, therefore, corresponding with the situation of the patient.

If one accepts that the claim about the certainty of the nurse's recognition is raised on account of an *interpretation* which presupposes a cognitive principle and not on a particular kind of knowledge, then Benner and Wrubel (1989), who are of the opinion that the nurse's recognition at the expert stage corresponds with the situation of the patient repeat the claim of cognitive

theories of knowledge. It means also that Benner et al's (1996) assertion that the nurse's recognition at the proficient and expert stage corresponds with the situation of the patient repeats the claim of cognitive theories of knowledge; that is, Benner et al reiterate their notion - referred to earlier - concerning the "common sense" of the Western tradition and the discipline of nursing for the nurse at the proficient and expert stage, namely: that her recognition as informed by the knowledge in her mind "corresponds" with the situation of the patient.

If one accepts a cognitive interpretation of recognition then it can also be said that Benner and her colleagues fail to notice the implicit claim about a correspondence between the nurse's recognition when informed by her *practical as well as her theoretical knowledge* and the situation of the patient as made by nursing theorists, for example, Johnson (1959a).

Contemplating the kind of contribution nursing offers to the care of patients as opposed to the contributions made by other professions, for example, medicine, Johnson notes that what nursing has been offering so far "depends upon the individual nurse concerned" (1959a:199). The nurse's contribution is described as:

> largely experientially derived, frequently technical in character, often based on trial and error approaches, and even intuitive in nature (Johnson, 1959a:199).

Experientially and even *intuitively* gained knowledge, which is precisely the kind of knowledge Benner et al (1996) call practical (as will be discussed in Chapters Four to Eight) informing the nurse's recognition is considered by Johnson, I suggest, to correspond with the situation of the patient in the sense of being "helpful". She writes:

> That our contributions have so often been helpful is probably because our experientially derived methods have been tested for many years (Johnson, 1959a:199).

Johnson takes it for granted that the nurse's practice informed by her practical knowledge ("experientially derived") which she describes as having been "helpful" has been recognized also by the patient as being 'helpful', that there is a correspondence of the nurse's recognition in terms of 'helpful' with the situation of the patient.

Importantly, Johnson is of the opinion that the nurse's contribution to the care of the patient can be increased when based on a "science of nursing". She writes:

> We can *increase our knowledge and understanding* of people: biologically, intrapersonally, interpersonally, and as members of society. We can use that knowledge to *sharpen our observations* of their requirements for nursing care. We can *increase our skills in perception* ..... We can seek to base our approaches to patients on firmer foundations by clarifying in our own minds what we are trying to do, why, and what scientific knowledge is involved (Johnson, 1959a:199; emphasis mine).

In effect, Johnson is saying that a "science of nursing" will "sharpen" and "increase" the nurse's "skills" of recognizing the situtation ("requirements") of the patient. Johnson is suggesting that the nurse's recognition of the situation of the patient founded on theoretical knowledge ("science of nursing") will be more effective than her practical knowledge in being helpful in observing the *patient's* "requirements for nursing care". That is, Johnson is implicitly claiming that the nurse's recognition informed by her theoretical knowledge ("science of nursing") is more certain to correspond with the situation ("requirements") of the patient than her recognition informed by her practical knowledge.

Implicitly asserting that the nurse's recognition when informed by her practical knowledge *as well as* by her theoretical knowledge ("science of nursing") to correspond with the situation of the patient, whereby the latter is

apparently more certain than the former, Johnson repeats the claim of cognitive theories of knowledge.

While Benner and her colleagues and Johnson are seen to repeat the claim of cognitive theories of knowledge, they do so by exchanging, as will be discussed in this thesis, one cognitive principle (for example, the *ego* of Descartes) with another cognitive principle, such as conceptions of nursing as conceived by nursing theorists (Johnson); or the development of "skills of seeing" and practical knowledge of the nurse in everyday work (Benner et al).

My interest is to show how the nurse's certainty, understood as the achievement of claims raised by Johnson's and Benner et al's cognitive interpretations of the nurse's recognition, creates a social distance between nurse and patient by excluding the patient's recognition as produced through her recognition from her recognition.

Repeating the Claim of a Non-cognitive Interpretation

Theories of knowledge which have a non-cognitive principle as their condition of interpreting the person's recognition, such as Derrida's *différance*, claim, I have shown above, that a correspondence between the nurse's recognition and the situation of the patient is uncertain.

This view contrasts with Benner et al (1996) who assert that the recognition of nurses at the advanced beginner stage is not corresponding with the situation of the patient *because* it is based on theoretical knowledge from nursing school. The assertion about the uncertainty of a correspondence between nurses at the advanced beginner stage and the patient depends, in the opinion of Benner et al, on the *kind* of knowledge informing their recognition: theoretical knowledge from nursing school.

However, if one accepts that the uncertainty of the nurse's recognition is based on an *interpretation* of recognition which presupposes a non-cognitive principle

rather than on a particular kind of knowledge, then it can be said: the assertion of Benner et al about the uncertainty of a correspondence between the nurse's recognition at the advanced beginner stage informed by her theoretical knowledge from nursing school and the situation of the patient is *repeating* the claim of non-cognitive theories of knowledge.

If one accepts a non-cognitive interpretation of recognition, then it can be said further that Benner and Wrubel underline the impossibility of raising the claim about a correspondence between the nurse's recognition and the situation of the patient when they emphasize that:

> Nursing theorists have been overly constrained by the stringent requirements of the received view of formal theories and have found it difficult to capture the embodied, relational, configurational, skillful, meaningful, and contextual human issues (1989:6).

Benner and Wrubel are implying here, as I have noted earlier, that the nurse's recognition informed by conceptions of nursing (theoretical knowledge) of nursing theorists is not capturing, that is, not corresponding with the various "human issues" in the situation of the patient.

If one accepts a non-cognitive interpretion of recognition, then it is possible to suggest that Benner and Wrubel (1989) and Benner et al (1996) overlook that *conceptions of nursing* of nursing theorists are concerned that "scientific knowledge", which is to say theoretical knowledge, does not fit the "individual" situation of the patient.

This is pointed out, for example, by Levine (1966). She stresses that the nurse's practice based on scientific knowledge requires the recognition of the individual situation of the patient: "Nursing intervention must be founded *not only* on scientific knowledge, but specifically on recognition of the individual's behavioural responses" (Levine, 1966:2452; emphasis mine). Levine implies that

the nurse´s practice based on scientific knowledge is not corresponding with the individual situation of the patient and, therefore, the nurse must "specifically" observe how the "individual" patient responds to her practice.

The uncertainty about a correspondence between the nurse´s recognition informed by her theoretical knowledge learned in nursing school and the "specific" situation of the patient is, moreover, the focus in *The Dynamic Nurse-Patient Relationship* by Orlando (1961).

Orlando notes that the nurse in "a minimum of two and a maximum of five years ... must assimilate and apply to practice a wide range of principles from the basic and applied sciences, and all the medical specialities as well as mental health and public health concepts" (1961:1).

On the other hand, the nurse "must", according to Orlando, deal with the "specific" situation. Demanding that the nurse "must" discover the "meaning" in the "*immediate* nursing situation in order to help the patient" (1961:1; emphasis mine), Orlando implies that the nurse´s recognition informed by all the theoretical knowledge she acquired in nursing school is not corresponding with the particular situation of the patient.

Orlando (1961) and Levine (1966), I suggest, implicitly reject the claim of cognitive theories of knowledge about a correspondence between person and object and implicitly support the claim of a non-cognitive theory of knowledge about the uncertainty of a correspondence between the nurse´s recognition and the situation of the patient.

Moreover, Orlando (1961) presents, in considering the nurse´s uncertainty of recognizing the "meaning" in the particular situation of the patient, as this thesis will show, a non-cognitive interpretation of the nurse´s recognition. She offers, on the other hand, a minimal cognitive interpretation of the nurse´s recognition as the ´solution´ to the uncertainty of the nurse´s recognition.

Orlando's 'solution' (a minimal cognitive interpretation) to the uncertainty of the nurse's recognition, as will be discussed, differs in a crucial sense from the one Benner et al conceptualize. Benner et al's 'solution' concerning the uncertainty of the advanced beginner nurse's recognition of the situation of the patient is a cognitive interpretation of the nurse's recognition at the proficient and expert stage.

Overview

In the last two sections I have highlighted how the work of nursing theorists can be considered to repeat the claims of cognitive theories of knowledge (correspondence between person and object) and non-cognitive theories of knowledge (uncertainty about that correspondence). This sets the stage for subsequent chapters.

The next one - *Chapter Two* - analyses Orlando's (1961) idea of "exploration" to be a non-cognitive and a minimal cognitive interpretation of the nurse's recognition. *Chapter Three* deals with Johnson's (1974) work in order to elucidate how the development of conceptions of nursing imply a cognitive interpretation of the nurse's recognition. And I exemplify how the nurse's recognition when based on Abdellah's (1960) or Roy's (1984) conceptions of nursing of 'the whole patient' is not corresponding with 'the whole patient'.

Benner et al's work (1996) is examined in *Chapter Four* by discussing the difference between the principles Benner et al and Dreyfus and Dreyfus (1996) presuppose in order to explain the nurse's skill acquisition as a move through stages from novice or advanced beginner to competency and then to proficiency and expertise. *Chapter Five* considers Benner et al's understanding of theories of knowledge to be descriptions rather than interpretations. In *Chapter Six* Benner et al's idea of the nurse's development of "skills of seeing" and practical knowledge is shown to constitute a cognitive conception of the nurse's recognition at the proficient and expert stage. *Chapter*

Seven explores how Benner et al add the nurse´s emotions to their cognitive conception about the nurse´s progression from the stage of advanced beginner to expert. *Chapter Eight* analyses Benner et al´s claim about an "intuitive link" between the expert nurse´s recognition and subsequent action to denote an automatic action of the nurse. *Chapter Nine* shows how Benner et al add the notion of caring to their cognitive conception about an advance in the nurse´s recognition from the advanced beginner to the expert stage. *Chapter Ten* turns to Benner et al´s claims about the expert nurse´s recognition of the "patient as a person". *Chapter Eleven* brings out the difference between Orlando´s ´solution´ and Benner et al´s ´solution´ to the uncertainty of the nurse´s recognition and is followed by a *Summary*.

CHAPTER TWO

ORLANDO

Introduction

In *Dynamic Nurse-Patient Relationship* Orlando (1961) reports part of the findings of a research project carried out between 1954 and 1959. The book does not contain a research report. Orlando only states that the research was carried out "by observing and participating in experiences with patients, students, nurses, service and instructional personnel" (1961:VII).

But Orlando informs the reader that the purpose of the study was to find out how a particular nursing practice could be integrated which "helps patients maintain or restore their sense of adequacy or well-being in stressful situations associated with their illness" (1961:VII). Orlando´s hypothesis is that the physician´s diagnosis of an illness and concomitant treatment affect the "physical and mental comfort" of the patient (1961:5).

The patient´s "physical and mental comfort" being affected as a result of medical diagnosis and treatment, Orlando circumscribes with "needs" the patient has. A need is first defined as a "requirement" of a patient in a situation of illness which, when supplied, is seen to improve the "well-being" of the patient (Orlando, 1961:5). Later, this definition is augmented, when Orlando asserts that the fulfillment of the patient´s requirement or need in a situation of illness contributes "simultaneously to the mental and physical health" of the patient (1961:9).

Supplying "the help a patient requires in order for his needs to be met" (1961:8) is, in the opinion of Orlando, the responsibility of the nurse. But before the nurse is able to meet the needs of the patient it is necessary, according to Orlando, that the patient´s needs for help have been perceived by the nurse. In this context Orlando

draws the distinction between the nurse's "understanding of general principles" and the "meanings which she must discover in the immediate nursing situation in order to help the patient" (1961:1).

This distinction has some consequences. In particular, it entails that the nurse "first attempts to understand the meaning to the patient" (Orlando, 1961:1). She should do this in order to find out whether her perception of the "immediate nursing situation" of the patient constitutes a *need* from the patient's perspective; that is, whether the nurse's perception of the patient's need corresponds with the patient's perception of it.

In relation with Orlando's definition of a "nursing situation", I elucidate, first, how the nurse's perception is informed by her knowledge of general principles and feelings. Second, I will show how her idea of an exploration as an exchange of perceptions between nurse and patient is, on one hand, a non-cognitive interpretation of perception; on the other hand, a minimal cognitive interpretation of perception. Third, I discuss how her notion of a nursing action decided upon "deliberatively" is the enactment of claims in everyday work as put forward by her interpretations of perception and how her notion of "automatic activities" can be considered as the enactment of a claim in everyday work as raised by a cognitive interpretation of perception.

Perception Based on General Principles and Feelings

A "nursing situation" consists, for Orlando, of three elements: the "behaviour" of the patient, the "reaction" of the nurse to the behaviour of the patient and, thirdly, the actions of the nurse "designed for the patient's benefit" (1961:36).

Orlando divides, in turn, the nurse's "reaction" to the behaviour of the patient into three aspects: the nurse's "perception" of the patient's behaviour; the nurse's "thoughts stimulated by the perceptions"; and the nurse's

"feelings in response to these perceptions and thoughts" (1961:40). Orlando appears to separate the nurse´s perception from thought, that is, from her knowledge of general principles of ´the sciences´; and she seems to separate the nurse´s feelings from her knowledge of general principles and thus from her perception.

The issue to be clarified is whether Orlando thinks it possible that the nurse is able to perceive the behaviour of the patient *apart* from her knowledge of general principles and her feelings. I will discuss different statements of Orlando which imply such ´separation´ in order to show how the nurse´s perception is, for Orlando, based on her knowledge of general principles and feelings.

Orlando expresses the possibility that the nurse perceives the behaviour of the patient apart from her knowledge in the following quote: "When the nurse perceives a patient, the thoughts which automatically occur to her reflect the meaning or interpretation she *attaches* to her perception" (1961:40; emphasis mine). As if the nurse is seen to apply her knowledge to her perception after the act.

Here is another statement which implies that the nurse perceives the behaviour of the patient apart from her knowledge of general principles. Orlando writes: "it might be suggested that the nurse explore perceptions first" (1961:44). Orlando is suggesting here that the nurse tells the patient about her perception *before* she attaches her knowledge of general principles (thought) and feelings to it. Because, in her opinion, the nurse "may waste much time in exploring thoughts as they occur to her, only to find out *each* time that they are incorrect" (Orlando, 1961:44; emphasis mine).

Orlando makes it rather clear that she does not assume a correspondence between the nurse´s perception *once* her "thoughts" (knowledge of general principles) have been applied to it and the behaviour of the patient. Each time the nurse would attach her knowledge to her perception and then explore her knowledge with the patient, she may find

that it is "incorrect"; that is, not corresponding with the "meaning" the patient has of his behaviour.

If the nurse´s perception of the behaviour of the patient is obviously not considered to correspond with the behaviour of the patient once her knowledge of general principles have been applied to it, then it follows that there would be no need for the nurse to explore her perception with the patient "first", that is, before she has applied her knowledge to her perception. The nurse could be certain that she perceives the "meaning" the patient has about his behaviour rather than her knowledge of general principles. She could, for example, be certain that her perception, apart from her knowledge of general principles and feelings, grasped the behaviour of the patient *as it is*.

But Orlando precludes such possibility as the following two quotes show. She states: "What the nurse *automatically* perceives or thinks *cannot* ordinarily be controlled (1961:41; emphasis mine). And, again, the "nurse´s perceptions, thoughts and feelings are experienced almost *simultaneously*" (1961:48; emphasis mine). In other words, the nurse cannot but perceive the situation of the patient informed by her knowledge of general principles and feelings.

Still another reference seems to indicate that Orlando´s interest is to separate the nurse´s perception from knowledge and feelings for the sake of analysis only. She writes: "Although it is extremely difficult to separate perceptions from thoughts and feelings, it is worth trying to do so in order to focus attention on how one aspect of the nurse´s reaction may affect the other aspects" (Orlando, 1961:40).

But even her attempt of separating those aspects for the sake of analysis, Orlando succeeds to undermine, because she states: "What the nurse perceives, thinks, and feels about the behaviour of the patient will, of course, reflect her individuality" (1961:40).

If the nurse´s "individuality", which I take to be constituted by her knowledge and feelings, are reflected by the nurse´s perception, thoughts (knowledge of general principles) and feelings, then Orlando undermines her attempt of separating perception, knowledge and feelings for the purpose of an analysis.

This account allows to conclude, then, that, for Orlando, the nurse´s perception of the behaviour of the patient is informed by her knowledge of general principles and feelings.

Perception not Corresponding

The insight Orlando gained about the nurse´s perception through her research is formulated in a "nursing principle". According to this principle:

> The nurse does *not* assume that any aspect of her reaction to the patient, (that is, the nurse´s perception informed by her knowledge of general principles and feelings, I.V.) is correct, helpful or appropriate *until* she checks the validity of it in exploration with the patient (Orlando, 1961:56; emphasis mine).

Stating that the nurse cannot be certain that her perception informed by her knowledge of general principles and feelings is "correct, helpful or appropriate", that is, *not* corresponding with the behaviour of the patient, unless verified with the patient, Orlando implicitly rejects the claim of cognitive theories of knowledge about a correspondence between person and object.

Furthermore, in drawing out the consequences from her insight about the nurse´s perception, Orlando presents a non-cognitive interpretation of the nurse´s perception. She writes: "What the nurse automatically perceives or thinks cannot ordinarily be controlled, but she can learn" to formulate her "perceptions or thoughts", that is, her perceptions informed by her knowledge of general principles and feelings, "by questioning and wondering

about the meaning of them to the patient" (Orlando, 1961:41). She continues:

> This kind of exploration enables the patient, in turn, to respond by expressing the meaning the nurse's perception or thought has to him (Orlando, 1961:41).

Orlando's idea of the nurse's "exploration" in that the nurse articulates her perception ("meaning") of the behaviour of the patient to the patient so that the patient can articulate his perception ("meaning") of it to the nurse, in short, an exchange of perceptions between nurse and patient, implies that the nurse's perception of the behaviour of the patient effects the perception the patient has about his behaviour.

Orlando's insight (claim) that the nurse's perception of the behaviour of the patient is not corresponding with it unless verified with the patient can be thought of as a non-cognitive interpretation in as far as her idea of exploration: exchange of recognitions between nurse and patient, does not presuppose the nurse's knowledge of the object (patient) as its condition of interpretation, that is, of claiming a correspondence between person and object.

To put it differently, Orlando's idea of "exploration", understood as an exchange of recognitions between nurse and patient, is a non-cognitive conception of recognition because it implies that the nurse's knowledge of general principles and feelings is uncertain to correspond with the patient.

Correspondence Accomplished

While Orlando's idea of "exploration" as an exchange of perceptions between nurse and patient about the behaviour of the patient can be considered as a non-cognitive

interpretation of perception, it conceptualizes, at the same time, the condition of accomplishing a correspondence between nurse and patient: exchange of perceptions between nurse and patient about the behaviour of the patient.

But since this accomplishment of a correspondence presupposes 'only' an *exchange* of recognitions between nurse and patient her 'solution' to the uncertainty of the nurse's recognition informed by her knowledge of general principles is, I suggest, a minimal cognitive conception. That is, the rational precondition of claiming a kind of correspondence is the exchange of knowledge (recognitions) between nurse and patient, rather than the nurse's knowledge.

If this is so, then the nurse's failure, for one reason or another, of articulating her perception of the behaviour of the patient to the patient so that the patient can articulate his perception of his behaviour in relation to it entails that the perception of the patient remains absent from the nurse's perception. That is, a kind of correspondence between nurse and patient about the behaviour of the patient is not accomplished.

On the other hand, the patient who is, for one reason or another, not articulating his perception of his behaviour in relation to the nurse's perception of it, withholds his perception from the nurse's perception of his behaviour. This means that the patient participates in not accomplishing a kind of correspondence between himself and the nurse about his behaviour.

With the following example presented by Orlando, I want to illustrate the failure as well as the success of accomplishing a kind of correspondence between nurse and patient about the behaviour of the patient and the implication of either achievement with regard to the social distance between nurse and patient.

This is the description given by Orlando:

> Two days previously, a patient had been transferred from a locked to an open ward. On this particular day he was walking down the hall when the head nurse said to him, "Your dental appoinment is at 10.00 a.m." The patient looked startled but he did not speak, blinked his eyes and then squinted. The head nurse asked, "What's the matter?" but did not pursue her questioning and allowed the patient to walk away. At 10.30 a.m. the dental clinic notified the nurse that the patient had not kept his appointment. At 3.00 p.m., when the patient returned, the head nurse asked, "Where have you been?" The patient did not answer. Later the nurse said to the doctor, "This patient is very confused today, and I'm really concerned about him. He left the ward at 9.45 a.m. to go to the dental clinic, but he didn't get there. He wouldn't tell me where he had been when he returned at 3.00 p.m. I'm not sure it's safe to keep him on the open ward."
>
> Arrangements were made for the patient to be transferred back to the locked ward. When the patient arrived, he said to the nurse whom he knew, "I don't belong here, I was getting better." "Can you tell me why you think you don't belong?" The patient did not answer. The nurse then said, "Since I don't know why you think you don't belong, I'll tell you what I know. They were concerned about you because they thought you were confused again. You left the ward for the dentist's office but you got lost somewhere, and, to be sure you are protected, they transferred you here. Does any of this make sense to you?" "It makes sense, but I didn't get lost and I wasn't confused. I was scared - afraid of that *damn* drilling! I was shaking all over and I just couldn't get up nerve enough to go. I sat in the corner of the coffee shop for hours hoping I'd find the courage to go. Finally, about 2.30, I felt better and went to the clinic, but they couldn't take me. They told me they would make another appointment (in Orlando, 1961:53).

Here is a patient who is told by the head nurse about his appointment with the dentist in the morning (10.00 am). The head nurse establishes a correspondence with the

patient in terms of a particular information; in doing so, she produces the patient´s perception of this information and thus his behaviour.

The head nurse seems to be aware that her information affected the patient somehow, because she asks "What´s the matter?" The patient does not respond; he keeps the perception of his behaviour as produced through the head nurse´s information, which he reveals later as being "scared - afraid of that *damn* drilling", from the head nurse´s perception of his behaviour. The patient is not helping to accomplish a correspondence between himself and the head nurse about his behaviour, creating his own social distance to her: he walks away and sits in the coffee shop for hours in order to work up enough courage to go to the dentist.

When the patient returns in the afternoon (3.00 pm) to the ward, the head nurse, who had been notified by the dental office that the patient did not get there in time for his appointment, asks the patient "Where have you been?" Again, the patient is not articulating his perception of his behaviour in relation to the head nurse´s question; nor does he take the opportunity to tell her his reaction concerning the information she gave to him about the appointment with the dentist at 10.00 am. Keeping silence about his perceptions, the patient only further distances himself from the head nurse.

The social distance between the patient and the head nurse is even more enhanced when the head nurse, who appears to be concerned about the patient, articulates her perception of the patient´s behaviour to the physician rather than to the patient that he is "very confused today".

After the patient has been returned to the "locked" ward, the nurse there relays the perception of the head nurse from the "open" ward of the patient´s behaviour to the patient. The patient now discloses his perception as produced through the head nurse´s information about the appointment with the dentist to the nurse. This exchange of perceptions accomplishes a kind of correspondence

between the two about the behaviour of the patient as effected by the head nurse´s information and can be considered as decreasing the social distance between patient and nurse.

Nursing Actions

As noted earlier, the third element in Orlando´s definition of a "nursing situation" are the "nursing actions which are designed for the patient´s benefit" (1961:36). Nursing actions are more likely to benefit or help the patient, in the opinion of Orlando, when the nurse explores her perception of the situation of the patient "*with* the patient *before* deciding on which action to follow" (1961:61; emphasis mine).

On the view that Orlando´s idea of an "exploration" (exchange of perceptions between nurse and patient) is a non-cognitive interpretation of perception which claims that the nurse´s perception informed by her knowledge of general principles and feelings is not corresponding with the behaviour of the patient, Orlando is implying here that a kind of correspondence between nurse and patient about the situation of the patient has to be reached before a decision about the nursing action is made.

Which is to say, whether the behaviour of the patient as perceived by the nurse constitutes a *need* from the perspective of the patient before a decision about the nursing action meeting that need of the patient is made. A nursing action decided upon in this way, Orlando describes as an action decided upon "deliberatively".

Deliberation, understood as an exploration in terms of an exchange of perceptions between nurse and patient about the nursing action to be followed, continues throughout and after the performance of that action. Orlando notes: "Whether the nurse tries to find out what is happening to the patient before, during, or after the activity, she should permit the patient to react; in order to know how the patient anticipates, experiences or is affected by the

activity" (1961:62); or: "A deliberative nursing process has elements of continuous reflection as the nurse tries to understand the meaning to the patient of the behaviour she observes and what he needs from her in order to be helped" (Orlando, 1961:67).

Nursing actions decided upon and carried out deliberatively, that is, as a continuous process of exchanging perceptions between nurse and patient, are considered to be "more likely" to "help the patient" (1961:61). Since an exchange of perceptions is, for Orlando, the condition of accomplishing a correspondence, Orlando equates the idea of nursing actions helping the patient with the claim of accomplishing a correspondence between nurse and patient about the need of the patient and the nursing action chosen to meet that need including its performance.

The notion of a nursing action decided upon deliberatively can be considered, then, as the achievement in everyday work of the claim that the nurse´s perception is *not* corresponding with the behaviour of the patient as put forward by Orlando´s non-cognitive interpretation. A nursing action decided upon deliberatively can be seen, on the other hand, as the enactment in everyday work of the claim that a kind of correspondence can be accomplished between nurse and patient about the action as suggested by Orlando´s minimal cognitive interpretation of perception.

Nursing actions decided upon and carried out deliberatively, Orlando distinguishes from "automatic activities". An activity is defined as automatic, when the nurse acts on "any" perception of the situation of the patient without exploring her perception with the patient, that is, without accomplishing a kind of correspondence about the need of the patient *before* a decision about the nursing action to meet that need is taken. This, of course, implies that there may be no correspondence between nursing action and need of the patient. Indeed, any correspondence is likely to be purely fortuitous.

Since Orlando states that an automatic activity "may very well be ineffective" in helping the patient (1961:61), it can be surmised on the foregoing discussion that she connects the idea about ineffective nursing actions with the failure of accomplishing a kind of correspondence between nurse and patient about the need of the patient and subsequent nursing action to meet such need and its performance.

However, since theories of knowledge can be distinguished depending on the claims they raise in accordance with their presuppositions in terms of a cognitive or a non-cognitive principle, the notion of an automatic nursing action can be seen as the enactment in everyday work of the claim as made by a cognitive interpretation of perception: that the nurse´s perception *is* corresponding with the behaviour of the patient.

In everyday work there may be many factors influencing the way a nurse acts, *automatic* or *deliberatively* (in both senses). Ultimately, I think, however, that the action chosen by the nurse will reflect, implicitly or explicitly, her epistemological assumption about perception.

Orlando elaborates on the distinction between a nursing action decided upon in a deliberative or automatic way with an example. My interest, in connection with her comment about this example is to explicate how these activities illustrate the achievement of claims raised by Orlando´s non-cognitive and minimal cognitive interpretation and a cognitive interpretation of recognition.
This is the example presented by Orlando:

> Mrs. D. occupied the bed her nurse was making. Her eyes were focused on the abdomen of a patient in the next bed where another nurse was applying an abdominal binder. Suddenly, Mrs. D. pointed to the binder and said, "Can I please have a binder like hers?" Mrs. D.´s nurse was gathering the soiled bedclothes when a doctor appeared and asked her, "Did that

> report come back?" "Isn't it on the desk? I'll be right there," replied Mrs. D.'s nurse. The doctor left as the nurse answered Mrs. D., "You don't need one - you didn't have an operation like hers." Mrs. D. stared at the bedclothes as the nurse hastily left the room. Two seconds later a third nurse entered. As she handed Mrs. D. a medication cup, Mrs. D. asked, "Nurse, can I have a binder on my belly?" As the third nurse replied, "You had a normal, spontaneous delivery - you don't need one," the first nurse returned with clean towels and interjected, "I told you, you didn't need one." Suddenly Mrs. D.'s eyes dropped as she rubbed her lips together and picked at the nail of her little finger with her thumb. Both nurses who explained that the patient didn't need a binder left the room.
> The nurse who applied the binder to the other patient was now free. As she approached Mrs. D.'s bedside, she said, "I hear you ask for a binder. Can you tell me why, because we usually don't use them unless you've had an operation?" "Well, when my breasts were all swollen and the nurse wrapped them up tight, it helped them go down. I don't like this big belly I have now after the baby, and I figured if I wrapped it up tight it would go down too".
>
> The nurse understood what the request meant and the explanation the patient needed. The nurse explained the differences in the "*swelling*." In order for the nurse to measure the effect of the explanation, she asked, "Do you still think the binder will help?" "Oh, no, I understand you - it won't help. Isn't there something that will make this belly go down?" The patient was taught postpartum exercises and did them successfully (in Orlando, 1961, 62-63).

Orlando begins her comment by indicating that all three nurses, the one making the bed of Mrs. D., the nurse ("third" one) entering the room and handing Mrs D. her medication, and the one applying an abdominal binder to another patient, perceived the request of the patient ("Can I please have a binder like hers?", and "Nurse, can I have a binder on my belly?") as informed by their

knowledge of general principles. She writes: "All three nurses had similar data. They heard the patient´s request, knew their response to it and knew that the patient did not have a Caesarian section. The nurses *correctly understood* the routine use of abdominal binders" (Orlando, 1961:63; emphasis mine).

From the view of a cognitive interpretation of perception, these three nurses established a correspondence ("correctly understood") between their knowledge of "abdominal binders", Caesarian section, the ´routine´ situation of this particular patient *and* the request of this particular patient.

Orlando, then, undertakes to describe how the nurses perceived the patient´s request of ´a binder for her belly´ and their subsequent nursing action based on their perception of that request: "The automatic thoughts of all three had to do with the routine use of abdominal binders. Presumably the purpose of their verbal activity was also the same - to have the patient understand that she did not need a binder" (1961:63).

According to Orlando, one nurse achieved her "purpose", that is, her nursing action decided upon her perception of the patient´s request ("that she did not need a binder"), by "explaining that the patient did not have an operation", another nurse by "explaining that the patient had a normal spontaneous delivery" (1961:63).

Putting it another way, the explanation (nursing action) of both nurses based on their perception ("that she did not need a binder") is setting up a correspondence in terms of the patient *not* having had "an operation" and in terms of having had a "spontenous delivery" with the request of the patient: "Can I please have a binder like hers?" and "Nurse, can I have a binder on my belly?"

It seems rather obvious that the explanations of these two nurses are not corresponding with the request of the patient. Yet, from the point of view of a cognitive interpretation of recognition, each of the two nurses can

be certain that her explanation corresponds with the request of the patient.

Orlando hints at such certainty about a correspondence between the explanation of these two nurses and the request of the patient, because she states: "When the two nurses told the patient she did not need a binder, they thought they were correct, and, strictly speaking, they were" (1961:64). From the point of view of a cognitive interpretation of perception, Orlando emphasizes the possibility of assuming that their explanation based on their perception as informed by their knowledge of general principles and feelings is corresponding ("they thought they were correct") with the request of the patient. On this view, thinking that "they were correct" is ´strictly speaking´ achieving the claim of a cognitive interpretation about a correspondence between person and object.

But Orlando continues and asserts that the refusal of these two nurses to supply the patient with an abdominal binder "did not meet the patient´s need" (1961:64). How can Orlando make such an assertion, when she just stated that the *refusal* of the two nurses to give the patient what she requested: ´a binder for her belly´, was correct?

I have discussed that Orlando links the claim of nursing actions not helping the patient with the notion of automatic activities and these two nurses demonstrate, for Orlando, an automatic activity. In her opinion, they decided *not* to supply an abdominal binder without "*first* exploring for the meaning" of the patient´s request (1961:64, emphasis mine).

Demanding that they should have explored "first", that is, exchanged perceptions with Mrs. D. about the request in order to find out whether her request constitutes, in her opinion, a *need* requiring a nursing action or not, Orlando rejects the claim of a cognitive interpretation about a correspondence between the perception and subsequent nursing actions of these two nurses and the request of the patient.

Instead, following Orlando´s non-cognitive interpretation of perception, the nurse´s perception produces, in setting up a correspondence with the request of the patient, the perception of the patient. Mrs. D. illustrates how her perception came about through the perceptions and automatic nursing actions (explanations) of the two nurses when she is approached by the nurse who applied the binder to another patient. This nurse asks Mrs. D. "why" she was asking for a binder. The patient says: "Well, when my breasts were all swollen and the nurse wrapped them up tight, it helped them go down. I don´t like this big belly I have after the baby, and I figured if I wrapped it up tight it would go down too".

The articulation of the patient´s perception shows how the perception of the two nurses of Mrs. D´s request ("that she did not need a binder") is not corresponding with her need ("I don´t like this big belly") and, consequently, their nursing actions ("that she did not need a binder") are not corresponding with her need ("I don´t like this big belly").

Orlando´s notion of nursing actions decided upon deliberatively, understood as the enactment of the claim that the nurse´s perception is *not* corresponding with the behaviour of the patient, reveals an illusion; namely, that automatic nursing actions, understood as the enactment of the claim of a cognitive interpretation, correspond with the behaviour of the patient.
Orlando´s notion of nursing actions decided upon deliberatively, (enacting the claim of her non-congitive interpretation) discloses, moreover, how automatic activities (enacting the claim of cognitive interpretations), exclude the perception of the patient as produced through the nurse´s perception and nursing actions from the nurse´s perception of the behaviour of the patient. Since Orlando connects automatic activities with being ineffective in meeting the need of the patient it can be concluded that they are ineffective in as far as they exclude the perception of the patient from the

nurse's perception and thus creating a social distance between the two.

On the other hand, the notion of nursing actions decided upon deliberatively, understood as the enactment of the claim that a correspondence between nurse and patient about the behaviour of the patient can be accomplished as put forward by Orlando's minimal cognitive interpretation of perception is illustrated by the nurse who asked the patient "why" she wanted a binder. According to Orlando, this nurse "explained why it was not indicated, *but added a question* which explored the request" (1961:63; emphasis mine).

A nurse who would assume that her perception is not corresponding with the request (behaviour) of the patient is likely to add a question as the condition of possibility that the patient can articulate her perception in relation to her perception of the request and so on. Concerning this nurse, Orlando asserts that she: "found out the specific explanation the patient needed in order to understand that a binder was not indicated. Explaining the difference in the "*swelling*" enabled the nurse to achieve her purpose and thus to help the patient" (1961:63).

In other words, an exchange of perceptions between nurse and patient about the request of the patient helped to accomplish a kind of correspondence between the two about the request. Since Orlando links actions decided upon deliberatively with being helpful in meeting the need of the patient, it is reasonable to say that they are helpful, because they *include* the perception of the patient with regard to a particular activity and reduce, in this way, the social distance between nurse and patient.

Summary

In relation with Orlando's definition of a nursing situation (behaviour of the patient, the nurse's reaction

to that behaviour, and nursing actions), I have clarified that the nurse´s reaction to the behaviour of the patient which Orlando separates in turn into three aspects (the nurse´s perception, "thoughts stimulated by the perceptions", and "feelings in response to these perceptions and thoughts") is the nurse´s perception of the behaviour of the patient as informed by her knowledge of general principles from 'the sciences' and feelings.

I have pointed out that Orlando´s idea of "exploration" as an exchange of perceptions between nurse and patient about the behaviour of the patient as the consequence of her insight (claim) that the nurse´s perception informed by her knowledge of general principles and feelings is not corresponding with the behaviour of the patient unless verified with the patient, implies a non-cognitive interpretation of perception, since it is not presupposing the nurse´s knowledge as the condition of interpreting, that is, of claiming a correspondence between nurse and patient.

I have suggested that Orlando´s idea of "exploration" as an exchange of perceptions between nurse and patient is a minimal cognitive interpretation of perception, since it conceptualizes the condition of accomplishing a correspondence between nurse and patient as an exchange of perceptions between nurse and patient rather than the nurse´s knowledge. I have explicated the claim of her minimal cognitive interpretation of perception in relation with an example and noted the implication concerning the creation of social distance between nurse and patient in case that a correspondence about the behaviour of the patient is accomplished or not.

I have outlined Orlando´s notions of automatic actions and actions decided upon deliberatively. In relation with an example, I have explicated the former as the enactment in everyday work of the claim raised by cognitive interpretations of perception and the latter as the enactment of the claims raised by her non-cognitive and minimal cognitive interpretation of perception.

CHAPTER THREE

CONCEPTIONS OF NURSING

Introduction

I have stated in the Introduction that Johnson's (1959a) position appears to imply that the nurse's recognition informed by her practical knowledge as well as her theoretical knowledge (a "science of nursing") corresponds with the situation of the patient. If this is so, she is repeating the claim of cognitive theories of knowledge.

In order to develop a "science of nursing", Johnson suggests, however, that concepts of 'other' sciences need to be reformulated: "the science of nursing is conceived as developing through the *reformulation of concepts* drawn from the basic sciences and certain other applied sciences" (1959b:294; emphasis mine).

In a later paper, Johnson refers to the notion of concepts from 'other' sciences as "borrowed" theory: the kind of knowledge developed "in the main by other disciplines and *which is drawn upon by nursing*" (1968:206; emphasis mine). The idea of reformulating concepts from 'other' sciences, that is, "borrowed" theory, seems to be contained in the notion of "unique" theory.

Unique theory is, in the opinion of Johnson, the kind of knowledge "derived from the observation of phenomena and the asking of questions *unlike* those which characterize other disciplines" (1968:206-207; emphasis mine). Johnson seems to be saying that knowledge of "borrowed" theory reformulated through observing phenomena and asking questions in a way other than "borrowed" theory (observes phenomena and asks questions) turns that knowledge into a science (theory) unique to nursing.

Johnson, obviously, distinguishes between a science unique to nursing and "borrowed" theory, whereby the former is

derived through reformulating the latter. If this is so, then, I argue, that Johnson´s implicit assertion that the nurse´s recognition informed by a "science of nursing" corresponds with the situation of the patient, requires a cognitive principle ´unique´ to a science of nursing in order to make such assertion.

My aim in this chapter is, first, to show how Johnson´s idea of developing a science unique to nursing can be seen as an attempt of reformulating "borrowed" theory in the sense of exchanging cognitive principles of "borrowed" theories of knowledge with conceptions of nursing as the condition of making the claim about a correspondence between the nurse´s recognition based on a science of nursing and the situation of the patient.

Second, I present how Abdellah´s (1960) conception of nursing illustrates Johnson´s idea of reformulating "borrowed" theory into a science unique to nursing. Third, I outline Roy´s (1984) conception of nursing as another example of Johnson´s idea of ´reformulation´. I explicate, respectively, how the nurse´s recognition when informed by Abdellah´s or by Roy´s conception of the ´whole´ patient is not corresponding with the ´whole´ patient; and how those conceptions increase the nurse´s knowledge as the condition of producing and excluding the recognition of the patient, that is, the possibility of increasing the social distance between nurse and patient.

Conceptions of Nursing as Cognitive Principles

In her attempt to elucidate how a science of nursing can be generated, Johnson conceives the kind of knowledge required for "practice in nursing" as consisting of three parts, "each composed of a general type of knowledge": knowledge of order, knowledge of disorder, and knowledge of control (1968:207-208).

With one part, knowledge of order, I wish to exemplify how Johnson utilizes "borrowed" theory to identify the kind of knowledge nursing needs, and then reformulates that

knowledge into knowledge unique to nursing, that is, into conceptions of nursing as the foundation of a science of nursing.

Johnson describes knowledge of order as the kind of knowledge the "basic sciences" which are also referred to as the "biological and behavioural sciences" have brought forth "through the scientific method about man and his universe" (1968:207). She notes further that the biological and the behavioural sciences have provided knowledge each from *their* "perspective" and through *their* "focus" on particular objects and events "which helps us to understand biological man, psychological man, and social man" (Johnson, 1968:207).

Then Johnson claims that since nursing is dealing with "man", knowledge of order is the kind of knowledge nursing needs. But she goes on and implies that nursing theorists who are developing knowledge from the "perspective" and through the "focus" of the biological and behavioural sciences contribute to "borrowed" theory; which is to say, they are *not* building a science of nursing:

> I believe that nursing is concerned with man as an organized and integrated whole and this is the specific knowledge of order we require. .... While nurse scientists may, and some undoubtedly will, contribute to the general knowledge of order in man, it seems to me this is now, and will continue to be borrowed knowledge (Johnson, 1968:207).

Johnson makes it rather clear that nursing theorists who develop knowledge about "behaviour", that is, behaviour of man according to the perspective of the behavioural or the biological sciences are, in her opinion, serving the "cause of science" but not the "cause of nursing" when she further states:

> If we continue to observe behavior from the perspective of sociology, anthropology, or psychology; or if we continue to study disease with the aim of elucidating etiologies, properties, or

> life cycle; or if we continue to inquire into biological functioning or malfunction, we will be serving the cause of science, but not necessarily the cause of nursing" (Johnson, 1968:209).

But how are nursing theorists to find a perspective of nursing with regard to man so that they can stop employing the perspective of sociology, for example? Johnson suggests that such perspective is developed through "research". According to Johnson: "theory development unique to nursing will evolve only through the study of phenomena and the asking of questions in a way that is *not* characteristic of *any* other discipline" (1968:208; emphasis mine).

Yet she immediately concedes that the "determination of what phenomena to study and what questions to ask", that is, finding a perspective of nursing with regard to man, "will not be easy" (Johnson, 1968:208). Nonetheless, Johnson indicates how to determine such perspective of nursing. It is, for Johnson, a "fresh and creative approach" made possible through the "originality" of nursing theorists. She states:

> It will require a fresh and creative approach to the consideration of alternatives, and an originality expected only of the most outstanding scientists in other disciplines. Obviously, originality must be tempered by reason, and reason by the objective characteristics of the world of practice; *but only originality will take us away from the well-worn paths we have been following* (Johnson, 1968:208-209; emphasis mine).

Proposing the "originality" of nursing theorists as the source of determining a perspective of nursing concerning man, Johnson seems to have found, at last, a starting point for the development of a science unique to nursing.

On the other hand, she admits that she does not know how the "originality" of nursing theorists is going to achieve the task of finding a perspective of nursing. She writes:

"While my faith is strong, my ability to isolate and articulate what I consider to be the proper phenomena and perspective is limited" (Johnson; 1968:209).
Yet, Johnson is underrating herself here, because, by claiming that nursing is, as noted earlier, dealing with "man", Johnson has named the focus of nursing: man. What needs to be developed now is the perspective of nursing on man which is distinct from the "borrowed" perspective of the biological and the behavioural sciences on man so that a science of nursing is getting itself away from the "well worn paths" of the biological and the behavioural sciences.

Moreover, Johnson has already stated in 1959 that the perspective of nursing with regard to man is "health". She writes that the development of a "science of nursing" is given "direction" by "recognition of *nursing's specific* goal and contribution to the ultimate goal of optimum *health for all the individuals and groups*" (Johnson, 1959b:294; emphasis mine).

In 1974 Johnson refines nursing's perspective on health of man as: "concern" and help for the person to prevent illness or to recover from it. She writes:

> Within the organization of relationships and the way of life found especially in today's society, patients require precisely that which nursing, by heritage and current interest, seems *uniquely* qualified to offer: *concern for the person and assistance in living and coping with his circumstances and his environment in such a way that illness may be prevented or recovery may be facilitated* (Johnson, 1974:375; emphasis mine).

Having defined the perspective of nursing (Johnson (1974) speaks of "nursing's general purpose") with regard to nursing's focus: man, Johnson takes her consideration about the development of a science of nursing this time a step further, because she says:

> There remains the necessity of building a focused and cohesive conceptual system of

> the person to be served *and of deriving from that system an abstract model for practice* that will allow such a purpose to be fulfilled (1974:375; emphasis mine).

In other words, a "conceptual system" of nursing´s perspective (concern and help to prevent illness or to recover from it) of man ("the person to be served") is the condition of developing an "abstract model", that is, a conception of nursing informing nurses in their everyday work.

Johnson further points out that: "Most, if not all, of these individual efforts", that is, of individual nursing theorists, "to conceptualize the consumer of nursing service appear to have started from about the same point of view of nursing´s general purpose (1974:375), that is, to view man ("consumer of nursing care") in terms of ´concern and help to prevent illness or to recover from it´ and to conceptualize that concern and help. Conceptualizations of nursing´s perspective, that is, of concern and help for the patient, in short, conceptions of nursing are, for Johnson, the foundation of developing a science of nursing.

In this way, Johnson establishes, I suggest, conceptions of nursing as the condition upon which the assertion can be raised that the nurse´s recognition when informed by those conceptions of nursing, that is, by a science of nursing rather than by "borrowed" theory, corresponds with the situation of the patient. The point is, however, that Johnson only exchanges a cognitive principle (for example, the *ego* of Descartes) of "borrowed" theories of knowledge with another cognitive principle, such as, a conception of nursing.

Next I turn to Abdellah´s (1960) conception of nursing in order to exemplify Johnson´s idea of reformulating "borrowed" theory into a science unique to nursing and to explicate how the nurse´s recognition, when informed by Abdellah´s conception of the ´whole´ patient, is not corresponding with the ´whole´ patient.

Abdellah's Typology of Nursing Problems

In *Patient-centered Approaches to Nursing* Abdellah (1960) presents a typology of "nursing problems" and "nursing treatment". These typologies have been developed on the basis of three studies conducted by Abdellah (and possibly others) between 1953 and 1958.

One aim guiding the first research project was to find "a classification of common nursing problems" (Abdellah, 1960:12). This study resulted in a typology "comprising 58 groups of common nursing problems" (Abdellah, 1960:12). The second study, it is noted by Abdellah (1960), was more concerned with the steps nurses most frequently use in their everyday work to identify nursing problems, while the third study refined the typology by compressing the 'original' 58 groups of nursing problems to 21 (Abdellah, 1960:16).

Nursing problems of the final version of 21 nursing problems are described in the following way, for example: "1. To maintain good hygiene and physical comfort"; "2. To promote optimal activity; exercise, rest, and sleep"; or, "12. To identify and accept positive and negative expressions, feelings, and reactions"; or, "15. To promote the development of productive interpersonal relationships" (Abdellah, 1960:16-17).

In addition, a list of 12 "nursing skills" for the development of a "nursing treatment typology" was established of the kind, for example: "1. Observation of health status" in relation with a "well person", a "patient with physical health problem", and one "with emotional health problem" (Abdellah, 1960:16-17).

The assumption Abdellah makes about these typologies of nursing problems and nursing treatment is that they are the "principles of nursing practice and constitute the *unique* body of knowledge that is nursing (1960:12; emphasis mine). The development of such knowledge unique

to nursing involves, for Abdellah, "*converting* the *laws* derived from the physical, biological, and social sciences into principles of nursing practice" (1960:2; emphasis mine).

How Abdellah converted the "laws" of the "physical, biological, and social sciences" into principles unique to nursing is not further explained. One can only assume that she thinks to have achieved such conversion, because she claims that the typology of nursing problems "focuses on the physical, biological, social-psychological needs of the patient and provides a *more meaningful* basis for organization than the categories of systems of the body" (Abdellah, 1960:27; emphasis mine). Abdellah seems to be indicating here that, at least, the "categories of the body", if one takes them to stand for the "laws" of the physical and biological sciences, have been 'reformulated', to use Johnson's term, into "physical, biological" needs, that is, nursing problems, of the patient.

Adding the "patient as a person" to the Disease

In noting that the "physical, biological, social-psychological" nursing problems ("needs") of the patient are a "more meaningful" basis of "organization", Abdellah refers to the kind of knowledge on the basis of which a curriculum in schools of nursing and nursing practice in hospitals is considered to be organized.

Her point being that curricula in nursing schools (in the United States) up to the 1950s stressed "predominantly the physical aspects" of the patient (1960:3). Nurses learned, according to Abdellah, about the "disease condition" of the patient, but little about the "patient as a person" (1960:3).

On analogy with her assessment that nurses acquire knowledge about the physical and disease condition of the patient rather than about the "patient as a person", Abdellah claims that nursing practice puts the emphasis on

"physical aspects of nursing and medical care"; which is to say, little emphasis on the "patient as a person"; nurses are not seen to achieve a "comprehensive care of the 'patient as a whole'" (Abdellah, 1960:5).

Stating that the typology of nursing problems is a "more meaningful" basis of organizing a curriculum and nursing practice than "categories of the body", Abdellah is saying that the nurse's recognition informed by her typology grasps the physical and disease condition of the patient in her everyday work in terms of "physical, biological" nursing problems *as well as* the "patient as a person" in terms of "social-psychological" nursing problems. In short, the "patient as a whole".

Abdellah describes the "physical, biological, social-psychological" nursing problems also as "overt" and "covert" nursing problems. In relation with her notion of overt and covert nursing problems I want to explicate how the nurse's recognition informed by Abdellah's typology of "physical, biological, social-psychological" nursing problems is not corresponding with the "patient as a whole".

Increasing the Production of Social Distance

An overt nursing problem is, for Abdellah et al, an "apparent" condition of the patient in the sense of a physical disease condition, because she illustrates an overt nursing problem with an example of "a patient with a decubitus ulcer" (1960:6).

In contrast to an overt nursing problem, Abdellah states that a covert nursing problem is a "concealed or hidden" conditon the patient faces (1960:6). Such covert problem is linked with the social and the psychological condition of the patient. This comes out when she notes that covert problems "such as emotional, sociological, and interpersonal problems are often missed or perceived incorrectly" (Abdellah, 1960:7).

Abdellah illustrates both: overt and covert nursing problems with the following example:

> keeping a patient in bed with a heart condition will not achieve complete rest for his heart by slowing his pulse rate (overt nursing problem) if he is worried about the support of his family (covert nursing problem) (1960:7).

This example of the patient with a heart condition (overt nursing problem) underlines how the patient´s physical disease condition and concomitant treatment (bed rest) may affect the patient in more than one way. That is, the bedrest may lead to his puls rate slowing down, but it may lead also to concerns (covert nursing problem) of the patient. One concern might be that he is worried about the "support of his family", another might be that he is worried about his job, and so on.

From a slightly different perspective, Orlando underlines this point when she says that the fulfillment of the patient´s requirements contribute "*simultaneously* to the mental and physical health" of the patient (1961:9; emphasis mine).

More specifically, this example and Orlando´s insight indicate that a division of the patient, for example, into a physical disease condition of the patient and the "patient as a person", is epistemologically secondary. That is, the nurse´s recognition informed by her knowledge of Abdellah´s typology of nursing problems produces, in establishing a correspondence with a "physical, biological" problem of the patient, the recognition of the patient in relation to it *as well as* the recognition of the patient of his "social-psychological" problem(s).

Since the recognition of the patient of his "physical, biological" problem as well as of his "social-psychological" problem are effected by the nurse´s recognition of his "physical, biological" nursing problem, the patient´s recogniton *is*, as an effect, "hidden or concealed" from the nurse´s recognition. The nurse´s

recognition based on Abdellah's typology of nursing problems is not corresponding with the "patient as a whole".

On the contrary, the nurse who would assert that her recognition informed by Abdellah's typology of nursing problems corresponds with a "physical, biological" nursing problem recognized, excludes the recognitions of the patient ("physical, biological" and "social-psychological" problems) as produced through the nurse's recognition of a particular "physical, biological" nursing problem from her recognition of that problem - effecting a social distance between herself and the patient.

Conversely, the nurse's recognition informed by Abdellah's nursing problems produces, in setting up a correspondence with a "social-psychological" nursing problem of the patient, the recognition of the patient in relation to it *and* the recognition of the patient of his "physical, biological" problem(s).

The nurse who is certain that her recognition informed by Abdellah's nursing problems corresponds with a "social-psychological" nursing problem recognized, excludes the recognition of the patient ("social-psychological" and "physical, biological" problems), as produced through the nurse's recognition of a particular "social-psychological" nursing problem from her recognition of that problem, also resulting in a social distance between hurse and patient.

Abdellah's conception of nursing shows how adding knowledge about the "patient as a person" in terms of "social-psychological" nursing problems to the nurse's knowledge about the physical disease condition of the patient ("physical, biological" nursing problems), *increases* the nurse's knowledge as the condition of producing (and excluding) the recognitions of the patient in relation to her recognition.

Next I turn to Roy's (1984) conception of nursing which is rather complex and warrants a comprehensive presentation (which also serves a discussion in the Appendix that

problematizes the development of a science unique to nursing).

Roy's Conception of Nursing

According to Roy (1984), nursing "is dealing with the person, not only as a biological organism, but as a holistic adaptive system". On this assumption, Roy proposes "to describe adaptation as a process involving holistic functioning to affect health positively" (1984:36; emphasis mine).

In order to define the person as an adaptive system "functioning holistically to affect health positively", Roy explains first a "general notion" of a system and coping mechanisms which are then reformulated as a conception of nursing. This is how Roy explains a system:

> A system is a *whole* that functions as a whole by virtue of the interdependence of its *parts*. In addition to having wholeness and related parts, systems also have *inputs, outputs,* and *control* and *feedback* processes" (Roy, 1984:29; emphasis in the original).

Parts such as input, output, control mechanism, and feedback processes of mechanical systems may, in Roy's opinion, also be utilised to describe a living system "as a whole made up of parts that function as a unity for some purpose" (1984:30).

On this view, inputs or "stimuli" of a living system such as a person are taken to arise from the "environment outside the person and internally from the self". A pool of such stimuli constitutes, according to Roy, the person's "adaptation level" which represents the person's "own standard of the range of stimuli that can be tolerated with ordinary efforts (1984:30). The processes that control the persons's adaptation level are considered by Roy in terms of "coping mechanisms":

> We know that people have biological and psychological abilities to cope with a changing environment. Some *biologic mechanisms* are genetically determined, such as the amount of antihemophilic factor in the blood, a substance necessary for blood clotting. *Other innate mechanisms* are common to the species and include such factors as the self-sealing mechanism of the blood vessels. When it is disrupted, the cut end of a blood vessel constricts, thus helping to prevent excessive bleeding. *Mechanisms may also be acquired through such processes as learning*. For example, every student nurse learns how to apply pressure to the site to control local bleeding. *Psychological defense mechanisms* act in a similar way. If a fact is too anxiety-provoking, one can block it out by the use of mechanisms of denial. Whatever the change in the environment, be it a direct assault that causes injury or a subtle variation in psychological climate, the person has mechanisms to cope with the changing world (1984:30-31; emphasis mine).

In effect Roy states that biological, "other innate" processes, learning processes, and psychological processes enable the person to cope with changes affecting the person´s level of adaptation.

From such a "general notion" of coping mechanisms Roy claims to develop a "nursing science perspective of these adaptive processes". She describes these as a system with two basic internal processes: "the regulator and the cognator subsystems" (Roy, 1984:31).

Roy presents the regulator subsystem as receiving "input from the external environment and from changes in the person´s internal state" and as processing "the changes through neural-chemical-endocrine channels to produce responses" (1984:31). I quote Roy´s explanation of how the regulator subsystem is seen to function at length:

> the internal and external stimuli are *basically chemical or neural* and act as inputs to the central nervous system. The chemical stimuli travel through the

> circulatory system and may be transduced into neural inputs. The spinal cord, brain stem, and autonomic reflexes act through effectors to produce automatic, unconscious effects on the body responses. The chemical stimuli in the circulation influence the endocrine glands to produce the appropriate hormone. The responsiveness of target organs or tissues then effects body responses. By some unknown process, the neural inputs are transformed into conscious perceptions in the brain. Eventually, this perception leads to psychomotor choices of response which activate a body response. These bodily responses, brought about through the chemical-neural-endocrine channels, are fed back as additional stimuli to the regulator system (1984:31; emphasis mine).

The regulator subsystem involves physiological processes such as chemical, neurological, and endocrine responses which are seen to enable the body to cope with inputs from the environment.

The maintenance of cellular nutrition which involves the interrelation between hunger and blood sugar is, for Roy, an example that illustrates the regulator subsystem.

But nutrition can also, according to Roy, be examined as "another regulator process", since it is influenced by factors such "as culture, emotional state, appearance of food, and so forth. The regulator mechanisms seldom act alone, but are most often interactive with other human control processes" (Roy, 1984:33). Roy´s point is that: "Developing nursing knowledge will continue to explore this *interrelationship*, rather than focusing solely on the physiology involved (1984:33; emphasis mine).

The second subsystem of the person´s internal processes, the cognator, is considered to receive inputs involving:

> psychological and social factors as well as physical and physiological ones, including those that are the output of the regulator mechanisms (Roy, 1984:33).

The psychological, social, physical, and physiological stimuli, as well as the stimuli emitted from the regulator subsystem Roy designs to proceed "through various cognitive/emotive pathways". That is, to "trigger off four kinds of processes: perceptual/information processing, learning, judgment, and emotion" and to produce responses (1984:33).

Within each of these four processes, Roy states, "we can place knowledge that is currently known about these human abilities" (1984:33). In detail:

> Under perceptual/information processing, we may consider the person's internal activity of selective attention, coding, and memory. Learning involves such processes as imitation, reinforcement, and insight. The judgment process includes problem solving and decision making. Through the emotional pathways, the person uses defenses to seek relief and affective appraisal and attachment (1984:33; emphasis mine).

Roy further designs the four processes (in which she places current knowledge about particular processes just stated) to process input stimuli, for example, psychological ones, to produce responses. These responses are in turn designed to be carried through four "*effector modes*: physiologic, self-concept, role function, and interdependence" (Roy, 1984:33; emphasis mine). Each one of these modes presents, according to Roy, a particular "adaptive behavior" (1984:45).

Roy gives an example of how a cognator process might become manifest in "behaviour". With this example I want to show how a person informed by Roy's conception of the person as a holistic adaptive system will fail to recognize the person as a holistic adaptive system.

Creating an Almost Total Social Distance

Roy describes a teacher who presents an outline of a course to students in the first class of the semester. The teacher is then approached by a student who perceived that outline to entail "an unusual amount and quality of work" and wants to drop the course.

This is the example as given by Roy:

> A student comes to the teacher after the first class of the semester and tells the teacher that she wants to drop the course. As the teacher talks with the student, she learns that the student perceived an unusual amount and quality of work being demanded as the outline of the course was presented by the teacher. The student has focused attention on this one aspect of the situation and ignored other aspects, such as her abilities, interests, and future goals in this field. Although selective attention is an appropriate mechanism in some situations, in this case it has led to a constricted view of the situation so that the student acts hastily based only on the information to which she is attending (1984:33 and 35).

The teacher, informed by her knowledge of the person as a holistic adaptive system as defined by Roy, recognizes the student´s perception of the outline of the course ("unusual amount and quality of work") as "selective attention" (or as a "constricted view"), since the student´s perception ("unusual amount and quality of work") is seen to make other aspects of herself as an holistic adaptive system, such as, "abilities, interests, and future goals in the field", absent from her perception of the course outline.
However, while the teacher points out that the student perceives the course outline in terms of "selective attention", the teacher enacts the same gesture of *selective attention*, namely, recognizing the perception of the student of the course outline as "selective attention" and "ignoring" other aspects of Roy´s holistic adaptive

system. This is hinted at by Roy in her footnote to the example which states:

> This interpretation of the situation is oversimplified for use as an example. Because the person functions as a whole, *all the other cognator processes*, such as memory or avoidance of anxiety, could also be considered, *as well as any regulator influence* (1984:35; emphasis mine).

Roy is saying that the teacher's recognition of the student's perception of the course outline in terms of "selective attention" is not considering the student's perception in terms of "memory" or "avoidance of anxiety". The consideration of the student's perception as "selective attention" makes the aspects of "memory" or "avoidance of anxiety" and *all* the other aspects of the student's regulator and cognator subsystems absent from that consideration.

In case the teacher asserts that the recognition of the student's perception of the course outline in terms of one aspect, like "selective attention", is certain to correspond with the perception of the student of the course outline as "selective attention", such assertion would explicitly exclude the student's perception as produced through the teacher's recognition in relation to the aspect of "selective attention" *and*, since the "person functions as a whole", all the other aspects of the student's two subsystems from her consideration of the student.

The example reveals that a consideration of the student in terms of any aspect of the regulator and cognator subsystem *is* selective. It is not the oversimplification of the example that is the problem. Rather the impossibility of a 'holistic' recognition of the person in the sense that the teacher, informed by her knowledge of the student as an adaptive system "functioning holistically" in terms of two subsystems and all the aspects of it, grasps all these aspects *at once*.

Roy who claims that nursing is not dealing with the person only as a "biological organism", adds the person´s cognator subsystem to the person´s "biological organism" (regulator subsystem) illuminates how such knowledge increases the teacher´s knowledge of the student and thus of the possibility to produce and exclude the recognition of the student of all the aspects of those two subsystems creating thereby almost a holistic, that is, an almost total social distance between herself and the student.

Social Distancing Further Illuminated

This production of an almost total social distance when the nurse´s recognition is informed by Roy´s conception of nursing, I underline with an example from Orlando´s (1961) study. I also draw on Orlando´s action decided upon "deliberatively" and automatically, understood as the achievements of her non-cognitive and minimal cognitive conceptions of the nurse´s recognition in everyday work.

This is the example as presented by Orlando:

> The nurse entered with an intravenous tray. Abruptly, the patient sat up and yelled, "Get out of here! Nobody, but nobody is going to put that needle in me today. You people will drive me nuts." The nurse said, "I´m sorry, but it´s ordered daily." The patient replied, "I don´t give a damn - get it out of here." The nurse placed the tray on the bedside table, left the room, approached the head nurse and said, "The patient refuses her infusion and she really sounds like she means it." The head nurse responded, "I´ll go in and talk with her."
> The head nurse said to the patient, "You have to have the intravenous - it´s ordered daily .. there isn´t enough fluid in your body.. " The patient interrupted, "I´m not listening. If you don´t get that tray out of here, I´ll throw it through the window." The headnurse bit her lip and said, "O.K., I´ll see what the doctor says."

> Another nurse immediately approached the patient and said, "You really look upset. Can you tell me why?" The patient started to cry, then said, "Wouldn´t you be upset if the doctor promised you that if you drank all night you wouldn´t get the intravenous? I stayed awake drinking all night. I´m floating now. What more do they want from me?"
>
> The fluid intake notes confirmed the patient´s achievement. The doctor was notified and the order for intravenous was discontinued (in Orlando, 1961:79-80).

In this description, the nurse who enters with an "intravenous tray" tells the patient in terms of the ´tray´ that she is going to get an "intravenous" infusion *today*. It is fair to assume that the patient knew about the "intravenous" being "ordered daily", since, as the patient later reveals to another nurse at the very end of the description, the physician had promised her that if she would drink "all night" she would not "get the intravenous" today. The nurse with her ´tray´ (representing the "daily" order of the "intravenous") establishes, therefore, a correspondence with the ´fluid aspect´ of the patient in the sense of "there isn´t enough fluid in your body" (the explanation given to the patient by the head nurse).

If one accepts that the patient is a holistic adaptive system with a regulator and a cognator subsystem and their various aspects (Roy, 1984), then the nurse´s ´tray´ produces, in establishing a correspondence with one aspect of the patient: ´not enough fluid in your body´, the recognition of the patient with regard to that aspect: "I´m floating", but also with regard to all the other aspects of her two subsystems.

Since the recognition of the patient is an effect of the nurse entering with the ´tray´, the nurse can neither know the recognition of the patient concerning the aspect ´not enough fluid in your body´ nor concerning all the other aspects.

On this view, the patient´s outburst when the nurse enters with the ´tray´: "Get out of here! Nobody, but nobody is going to put that needle in me *today*. You people will drive me nuts" (emphasis mine), is not telling the nurse how she recognizes the aspect ´not enough fluid in your body´ as "I´m floating" and all the other aspects of her regulator and cognator subsystems so that a correspondence between herself and the nurse about that particular aspect and all the other aspects of her two subsystems can be accomplished *before* the ´order´ about the "intravenous" is enacted by the nurse today.

On the other hand, if the recognition of the patient is an effect of the nurse entering with the ´tray´, and if this effect concerns the aspect ´not enough fluid in your body´ and all the other aspects of her two subsystems, then the patient´s outburst: "Get out of here" and so on, while rather impolite and not informing the nurse about her recognition, can hardly be considered to be exaggerated, precisely because the nurse´s ´tray´ makes her recognition of the aspect ´not enough fluid in your body´ as "I´m floating" and of all the other aspects of her two subsystems *absent*.

The patient who wants to articulate her recognition in relation to the ´tray´ faces, however, a difficulty like that of the teacher discussed above. That is, she can articulate only one aspect at a time, for example, with regard to the aspect ´not enough fluid in your body´ as "I´m floating". Articulating her recognition as "I´m floating" is not articulating her recognition of any other aspect of her regulator and cognator subsystems, although all these other aspects, since they constitute, according to Roy, the patient as a *holistic* adaptive system, are present for the patient. The patient´s recognition of one aspect ´fluid´ as "*I´m* floating" seems to capture something of a ´holistic´ recognition of herself and seems, in this way, to support Roy´s idea of the person as a *holistic* adaptive system.

The nurse´s response to the patient´s outburst: "Get out of here" and so on, in terms of "I´m sorry, but it", that

is, the "intravenous" has "been ordered daily" confirms explicitly that she assumes a correspondence between her 'tray' and the aspect 'not enough fluid in your body' and excludes, thereby, the recognition of the patient concerning that aspect and all the other aspects of the two subsystems which she produced with her 'tray' and her statement that the "intravenous" is "ordered daily" from her recognition.

The nurse is about to act, following Orlando (1961), automatically, since she fails to explore the outburst of the patient *with* the patient *before* deciding to enact the physician's order "daily" *today*. The nurse's activity as signalled by her 'tray' and confirmed by her statement may not be, in Orlando's words, very helpful, since it is not seen as a need by the patient; there is no correspondence accomplished through an exchange of recognitions between nurse and patient about the situation of the patient as the condition of an action decided upon "deliberatively".

Instead, the nurse calls on the authority of the head nurse who reiterates that the "intravenous" is "ordered daily". Her confirmation of a correspondence between the 'order' and the aspect of the patient that there is 'not enough fluid in your body' *today*, enhances the exclusion of the patient's recognition of it as "I'm floating" *today* and of all the other aspects of her regulator and cognator subsystems from the nurses' recognition.

If the person as an adaptive system is "functioning holistically", according to Roy's conception of nursing, then the exclusion of the patient's 'holistic' recognition "*I'm* floating", that is, of all the aspects of her two subsystems, is almost totally distancing the patient from the head nurse's and the nurse's recognition of the patient's aspect 'not enough fluid in your body'. In other words, the only correspondence between the two nurses and the patient in that particular situation is the aspect of the patient's 'fluid of the body' *as such*.

The patient's reaction when she interrupts the head nurse is not overstating her case when she says:"I'm not

listening. If you don´t get that tray out of here, I´ll throw it through the window". The patient apparently attempts to stop the head nurse from further distancing her, that is, from putting "the needle in me today". So she will remove the tray (with the needle) which is already precariously near her body (the nurse "placed the tray on the bedside table") as far as possible: "through the window".

Summary

In this chapter I have pointed out that Johnson´s idea of developing a science unique to nursing involves a cognitive principle ´unique´ to a science of nursing in order to assert a correspondence between the nurse´s recognition informed by a science unique to nursing and the situation of the patient.

Since conceptions of nursing are, for Johnson, the foundation of a science of nursing, I have suggested that these conceptions provide the condition upon which a correspondence between the nurse´s recognition informed by those conceptions and the situation of the patient can be made.

I have pointed out, on the other hand, that the establishment of such condition implies an exchange of general cognitive principles of "borrowed" theories of knowledge, such as the *ego* of Descartes, with the conception of nursing of the individual nursing theorist.

I have presented the conceptions of nursing of Abdellah (1960) and Roy (1984) as an illustration of Johnson´s idea of developing a science unique to nursing through reformulating "borrowed" theory.
I have shown how the nurse´s recognition informed by these conceptions of nursing is not corresponding with the "patient as a whole" (Abdellah) or with the patient as a "holistic adaptive system" (Roy). Instead, I have explicated that ´adding on´ the "patient as a person" in terms of "social-psychological" nursing problems to the

physical disease condition of the patient ("biological, physical" nursing problems) (Abdellah) and the person as a cognator subsystem to the "biological organism" of the person (regulator subsystem) (Roy) increases the nurse´s knowledge informing her recognition of the patient and thus the condition of the nurse´s production and exclusion of the patient´s recognition of his situation leading to an increase in social distance between nurse and patient.

CHAPTER FOUR

FROM A PHYSIOLOGICAL TO A COGNITIVE PRINCIPLE

Introduction

In the Introduction to the thesis I have stated that if the claim about the uncertainty of a correspondence between the nurse´s recognition and the situation of the patient is derived from theories of knowledge which presuppose a non-cognitive principle instead of connecting this claim with a particular *kind* of knowledge, then the assertion of Benner et al (1996) about the uncertainty of the nurse´s recognition at the advanced beginner stage as informed by her theoretical knowledge from nursing school can be taken to *repeat* the claim of non-cognitive theories of knowledge.

Since theorizing about the person´s recognition of objects has apparently moved from a cognitive to a non-cognitive interpretation, repeating the claim of the latter would constitute a break with implicit assertions about a correspondence between conceptions of nursing and the situation of the patient of nursing theorists like Johnson, Abdellah, or Roy.

But I noted also in the Introduction that Benner and Wrubel (1989) and, particularly, Benner et al (1996) associate the claim about the certainty of the nurse´s recognition with the development of practical knowledge. If the claim about the certainty of recognition is raised, however, on account of cognitive theories of knowledge, then the assertion of Benner et al (1996) that the nurse´s recognition at the proficient and expert stage when informed by her "skills of seeing" and practical knowledge corresponds with the situation of the patient *only* repeats the claim of cognitive theories of knowledge.

To put it in another way, the attempt to solve the uncertainty of the nurse´s recognition at the advanced

beginner stage which has been noticed by Benner et al (1996), re-constitutes the gesture of cognitive theories of knowledge: presupposing a principle as the condition of interpreting recognition and thus of the possibility to assert a correspondence between the nurse´s recognition at the proficient and expert stage and the situation of the patient.

The cognitive principle Benner et al presuppose is, in ´essence´, the development of the nurse´s "skills of seeing" and practical knowledge in her everyday work with a particular group of patients over a number of years. The idea about the nurse´s development of "skills of seeing" and practical knowledge is, according to Benner et al, derived from the "Dreyfus Model of Skill Acquisition". In this chapter I elucidate, first, how the concept of skill acquisition, as presented by Dreyfus and Dreyfus in *Expertise in Nursing Practice* (Benner et al, 1996), presupposes a physiological principle in terms of the person´s brain processes. Second, I reveal how the brain processes Dreyfus and Dreyfus presuppose as the condition of explaining the nurse´s skill acquisition, are also the condition of impossibility of explaining the nurse´s acquisition of skill.

I will argue, third, that a study of the nurse´s skill acquisition which draws on Dreyfus and Dreyfus (1996), requires physiological accounts of the nurse´s brain processes from novice through to expert in order to validate the acquisition of her skill. Fourth, I show how Benner et al´s study of the nurse´s skill acquisition is based on cognitive accounts of the nurse´s ´brain processes´ and that their explanation of the nurse´s skill acquisition constitutes a cognitive (as opposed to a non-cognitive) conception of the nurse´s recognition.

The Nurse´s Acquisition of Intuitive Skill

In the chapter Dreyfus and Dreyfus contribute to *Expertise in Nursing Practice* they claim, following Aristotle, that professionals such as physicians and nurses need

"intuitive skill" for the application of theory to particular situations. For example, they write concerning medicine that: "The two areas where theory impinges on the concrete case, diagnosis, and treatment, are areas which would require experience and intuition" (Dreyfus and Dreyfus, 1996:33). Dreyfus and Dreyfus are indicating here that the physician or the nurse cannot be certain that their recognition as informed by "theory" is corresponding with the particular situation of the patient in space and time.

This uncertainty of the physician´s or the nurse´s recognition when informed by "theory" and the particular situation of the patient which Dreyfus and Dreyfus are noting here, Orlando (1961) already called attention to almost 40 years ago when she distinguishes between the nurse´s knowledge of general principles of ´the sciences´ she learned in nursing school and the "meanings" the nurse "must discover in the immediate nursing situation in order to help the patient" (1961:1).

Orlando solved this uncertainty of the nurse´s recognition. She did so, as has been discussed in Chapter Two, with her idea of "exploration" which entails an exchange of recognitions between nurse and patient as the condition of accomplishing a kind of correspondence between the nurse and patient about his situation (minimal cognitive conception).

In contrast to Orlando, Dreyfus and Dreyfus (1996) postulate the nurse´s acquisition of intuitive skill. In other words, Dreyfus and Dreyfus distinguish between two kinds of knowledge of the physician and nurse: "theory" and intuitive skill. With regard to nursing, they describe the difference as one between "theory of nursing" which includes "both the medical and nursing scientific knowledge that has been imparted to the trainee, mostly in nursing school", that is, her theoretical knowledge, and "the *´rules of thumb´* that are largely acquired during on-the-job-training and experience", that is, intuitive skill (Dreyfus and Dreyfus, 1996:29; emphasis in the original).

This acquisition of the nurse´s intuitive skill through "concrete experience in real situations" (Dreyfus and Dreyfus, 1996:36) is seen as a progression in five stages, from the stage of the novice nurse, advanced beginner nurse, to the stages of competent, proficient, and expert nurse. According to Dreyfus and Dreyfus, the novice nurse is one who knows theoretical knowledge from nursing school but lacks concrete experience in real situations and follows therefore rules in her everyday work.

The novice nurse can be distinguished from the advanced beginner who is able, since she has gained some concrete experience, to recognize "situational" objects of which she has no prior knowledge: "Through practical experience in concrete situations with meaningful elements which neither the instructor nor student can define in terms of objective features, the advanced beginner starts intuitively to recognize these elements when they are present" (Dreyfus and Dreyfus, 1996:38).

The point Dreyfus and Dreyfus make is while everyday work encourages the advanced beginner nurse to think of more rules, it "teaches" the advanced beginner also an "enlarged conception of what is relevant to the skill" (Dreyfus and Dreyfus, 1996:38). The ability of the person, for example, the nurse, to enlarge her conception through the recognition of situational objects is seen to have its condition of possibility in the person´s intuition: "the sort of ability, ..., that we use all the time as we go about our everyday tasks" (Dreyfus and Dreyfus, 1996:38).

Yet the advanced beginner nurse recognizes still less situational objects than the competent nurse (third stage). The recognition of situational objects becomes for the competent nurse, however, "overwhelming". In her everyday work there are "more situations than can be named or precisely defined, so no one can prepare for the learner a list of what to do in each possible situation" (Dreyfus and Dreyfus, 1996:39). The difficulty of the competent nurse is, in the view of Dreyfus and Dreyfus, that she cannot any longer fall back on her theoretical knowledge from nursing school. She has to decide for

herself what action to take, "without being sure that it will be *appropriate* in the particular situation" (Dreyfus and Dreyfus, 1996:39; emphasis mine); which is to say, that the nurse has to recognize whether her theoretical knowledge corresponds with the situation of the patient.

This constellation between the "necessity" of recognizing which knowledge will be corresponding with the particular situation and the "uncertainty" of the competent nurse about it introduces, following Dreyfus and Dreyfus, an important "new type" of relationship between the nurse and the particular situation. The competent performer becomes "more and more emotionally involved in his or her task, it becomes increasingly difficult to draw back and to adopt the detached rule-following stance of the beginner" (Dreyfus and Dreyfus, 1996:40).

The significant claim Dreyfus and Dreyfus propose concerning the nurse´s emotional involvement at the competent level is that it leads to a "replacement" of her rule-following stance which, if it occurs, sets in turn the stage for the nurse´s progression to the proficient and, finally, to the expert level, that stage where the nurse intuitively "sees" a correspondence with the situation of the patient and the action needed.

This acquisition of the nurse´s intuitive skill is, for Dreyfus and Dreyfus, "explainable in terms of brain processes, *but not* in terms of rule-based reasoning" (1996:38; emphasis mine). Dreyfus and Dreyfus ground their assertion that the nurse´s recognition at the proficient and expert stage "sees" intuitively, that is, corresponds with the situation of the patient and the action needed, on a "physiological" principle.

Brain Processes as Effects

Dreyfus and Dreyfus (1996) describe their physiological principle when they illustrate the replacement of the nurse´s rule-following stance with an involved stance at the competent stage (third stage in their concept of intuitive skill acquisition) with an example from driving.

In their account, a competent driver passes another car dangerously, so that only a quick response by the other driver prevents an accident. According to Dreyfus and Dreyfus, the competent driver "*can* respond to this experience in *one* of two qualitatively different ways" (1996:41; emphasis mine). Here is the first way:

> One response would be for the driver to consciously *decide* that one should hardly ever rush, and modify the rule used to decide to hurry. Or, perhaps, the rule for conditions for safe passing might be modified so that the driver only passes under exceedingly safe circumstances. These would be the approaches of the driver doomed to timidity and fear, and, by our definition, to competence (Dreyfus and Dreyfus, 1996:40; emphasis in the original).

Dreyfus and Dreyfus present the driver´s response to his experience of the near accident with regard to the modification of his driving rules as a decision he *can consciously* make. Yet, this conscious decision making process about which rules to change or not is seen to restrain the driver to get past the competent stage on to the proficient stage. A second, qualitatively different, way of responding is described as follows:

> one could accept the deeply felt consequences of the act without detachedly asking oneself what went wrong and, especially, why. If one does this, it is likely that one won´t be quite so likely to hurry in the future or to pass in similar situations, but one has a much better chance of ultimately becoming, with enough frightening or, preferably, rewarding experiences, a relaxed and expert driver. As we indicated ... it is innate and natural for driving behavior to be unconsciously enhanced through experience by synaptic brain changes without these changes taking the form of conscious or even unconscious rule-modification (Dreyfus and Dreyfus, 1996:40-41).

In effect, the driver´s response "to" the felt consequences of his experience of the near accident affects, due to "synaptic brain changes", an *unconscious*, that is, a bio-chemical enhancement of his driving behaviour. For Dreyfus and Dreyfus, the qualitative difference between the two responses of the driver to the experience of the near accident is one between an unconscious enhancing response and a conscious rule-modifying response.

Contrary to Dreyfus and Dreyfus, I wish to argue, that if the qualitative difference between an unconscious enhancing-response and a conscious rule-modifying-response of the driver "to" his experience of the near accident would be complete in the sense that they are *separate* responses, then the driver would be unable to recognize those unconsciously felt responses as an enhancement of his driving behaviour. The driver would not be able to know whether his driving behaviour has changed after the near accident or not; or, he would not even recognize that he had prevented an accident. Indeed, he would not recognize that he is driving.

So instead of accepting the claim that the driver can respond in one way *or* the other, it seems more plausible to me to suggest that the driver´s response "to" his experience of the near accident is simultaneously unconscious (which may or may not be enhancing, the latter possibly because of a "frightening" experience) and conscious (which may or may not result in rule-modification). (See also discussion on the mutuality of the nurse´s knowledge and emotions in Chapter Seven).

But more significantly, the driver´s unconscious *response* "to" the experience of the near accident comes ´too late´ in order to be the source (condition) of explaining the driver´s experience, that is, his recognition of the near accident. Or, more specifically, the biochemical brain changes leading to an unconscious response "to" the experience of the near accident are themselves effects of that very experience and cannot, therefore, be the source of explaining that experience.

Physiological Accounts of the Person's Brain Processes

On the other hand, if one accepts, for a moment, the possibility of explaining the nurse's recognition in terms of a physiological principle, then *claims* about the nurse's *acquisition* of intuitive skill would require physiological, that is, biochemical evidence of the nurse's brain processes in order to validate those claims.

To illustrate the point, Dreyfus and Dreyfus write concerning the nurse's "brain" at the proficient stage:

> As the brain of the performer acquires the ability to discriminate between a variety of situations entered into with concern and involvement, plans are intuitively evoked and certain aspects stand out as important without the learner standing back and choosing those plans or deciding to adopt that perspective (1996:41).

They are saying that through concern and involvement in a variety of situations the nurse's brain acquires the ability to discriminate; that is, "important" aspects in the situation of the patient and actions ("plans") in relation to it are "intuitively" recognized by the nurse. Dreyfus and Dreyfus assert here that, at the proficient stage, the nurse has recognized the "important" aspects in the situation of the patient; that there is a correspondence between her recognition of "important" aspects and the important aspects in the situation of the patient.

But since the assertion about such "intuitively" evoked correspondence of the nurse's recognition with the situation of the patient is, for Dreyfus and Dreyfus, only explainable in terms of "brain processes" (1996:38), biochemical accounts of those processes are needed to confirm that assertion; that is, to give physiological evidence that the nurse's brain at the proficient stage acquired an ability which it did *not* have at the stage of novice. This in turn would call for a longitudinal study of the nurse's biochemical brain processes from novice through to expert.

The upshot of this argument is that a study about the nurse´s skill acquisition which draws on Dreyfus and Dreyfus (1996), but is not based on physiological accounts of the nurse´s brain processes from novice to expert, offers an interpretation which replaces a physiological principle with another principle in order to explain the nurse´s skill acquisition.

I will now show how Benner et al´s study of the nurse´s skill acquisition, following Dreyfus and Dreyfus, gives *cognitive* rather than physiological accounts of the nurse´s skill acquisition.

Cognitive Accounts of the Nurse´s ´Brain Processes´

Benner et al (1996) present a study of the nurse´s skill acquisition that is based on accounts of nurses which were drawn from their interviews with nurses working in "critical care nursing".

Nurses participating in those interviews had been "*selected for their expected* level of practice (advanced beginner through expert) by supervisors who were asked to consider years of experience" (Benner et al, 1996:XVII; emphasis mine). Which means that Benner et al predetermine their study of the nurse´s skill acquisition by correlating the stages of skill acquisition from advanced beginner to expertise, following Dreyfus and Dreyfus, with the number of years nurses have been working in critical care nursing.

In more detail, accounts of nurses considered to be at the advanced beginner stage have been practicing critical care nursing for less than six months after their training. Accounts which are thought to exhibit competent and proficient practice come from nurses who have worked at least between two and three years in critical care nursing. These nurses may or may not have worked in other areas of nursing. Overall this sample of nurses has

practiced nursing less than five years after finishing their nursing training.

Accounts which are supposed to exemplify expert practice come from a sample of nurses who have worked in critical care nursing for more than five years, not counting the time of their training. The correlation between the stage of the nurse´s skill acquisition and her years of practice is augmented concerning this particular sample, because these nurses were already considered to be "superb" nurses by their head nurse or supervisor (Benner et al, 1996:XVII).

Benner et al, then, study the nurse´s acquisition of skill in terms of cognitive (instead of physiological) accounts of the nurse´s ´brain processes´.

Explaining the nurse´s skill acquisition in relation with those accounts as a progression from the advanced beginner stage to competency and then to proficiency and expertise, Benner et al´s study constitutes a cognitive conception of the nurse´s recognition at the proficient and expert stage. This statment is further supported, for example, in Chapter Six.

In the following one - Chapter Five - I discuss Benner et al´s understanding of theories of knowledge to be descriptions instead of interpretations of the person´s recognition.

CHAPTER FIVE

DESCRIPTIONS *versus* INTERPRETATIONS

Introduction

As I have pointed out in the Introduction and as I have re-stated in the previous chapter: Benner et al notice an uncertainty of the advanced beginner nurse´s recognition when informed by her theoretical knowledge from nursing school. In noticing this uncertainty, Benner et al, I have suggested, repeat the claim of non-cognitive theories of knowledge.

Benner et al´s solution to the advanced beginner nurse´s uncertainty, I have shown in the previous chapter, is the nurse´s skill acquisition from the stage of advanced beginner to expertise. Their explanation of the nurse´s recognition at different stages in the course of acquiring her skill constitutes, I have pointed out, a cognitive principle. It is the rational precondition upon which Benner et al found their assertion that the nurse´s recognition at the proficient and expert stage corresponds with the situation of the patient.

However, if theorizing about the person´s recognition has moved from a cognitive interpretation which claims a correspondence between person and object to be certain to a non-cognitive interpretation which claims a correspondence to be uncertain, then Benner et al´s solution to the uncertainty of the advanced beginner nurse´s recognition in terms of constituting a cognitive principle (and thus the condition of asserting that the nurse´s recognition at the proficient and expert stage is certain) moves ´backwards´. How is this move possible?

In order to grasp how Benner et al come to move ´backwards´, it is necessary to know that, for them, theories of knowledge are *descriptions* instead of *interpretations* of recognition.

In order to elucidate this statement, I will show, first, how, for Benner and colleagues, a non-cognitive theory of knowledge and a cognitive theory of knowledge describe, respectively, a "narrative" mode and a "logico-scientific" mode of obtaining accounts from nurses; that is, accounts of the nurse´s recognition of situations of patients in everyday work.

I highlight, second, how Benner et al´s understanding of theories of knowledge to be descriptions instead of interpretations of recognition entails an inversion of claims. Benner and colleagues associate a non-cognitive theory of knowledge with the nurse´s recognition that is ´corresponding´ and a cognitive theory of knowledge with the nurse´s recognition that is ´not corresponding´.

I point out, third, how Benner et al´s understanding of theories of knowledge to be descriptions rather than interpretations is the *raison d´être* of their conception about an advance in the nurse´s recognition as a move through stages from advanced beginner to expertise.

Interpretations rather than Descriptions

Benner et al´s study of the nurse´s skill acquisition in terms of nurses´ accounts is based on a certain "preunderstanding of human action and engagement" (Benner et al, 1996:351). One of the assumptions of their "preunderstanding" is that "the basic way that humans live in the world is in engaged, practical activity" (Benner et al, 1996:352).

And because that is so, Benner et al are of the opinion that "the method of study must try to access" such engaged practical activity. One way of accessing it is a "narrative form of expression" and involves asking:

> nurses for full narratives *about care of particular patients*, which includes the context and history of the episode, *the ways in which the situation presented*

> *itself* and how it evolved over time, and the nurse´s concerns and actions throughout the episode (Benner et al, 1996:353; emphasis mine).

Benner et al here indicate their assumption that nurses´ narratives (accounts) of particular situations of patients are seen to fully narrate the situation as it "presented itself"; that there is a correspondence between the situation including aspects, such as, its history, evolvement, and so on and the nurse´s narrative account of it; that is, the nurse´s recognition of the situation of the patient at a particular point in time and space which she talks about to the researchers at another point in time and space, possibly days, weeks, months, even years later, is taken to correspond with, for example, the history and evolvement of the situation of the patient nurses once observed.

Importantly, Benner et al distinguish this "narrative" mode of inquiry from a "logico-scientific" mode of inquiry (1996:354). The latter is characterized as a method that specifies "the terms up front" and constrains "the storying within the investigation to those terms defined a priori" (Benner et al, 1996:354).

Defining terms "up front" or "a priori", that is, the "logico-scientific" mode of inquiry, implies, for Benner et al, that the "complexity" of a narrative account may get lost: "Setting out the terms in advance reduces the complexity of the possible narrative" (1996:354). That is, researchers who are setting up questions in "advance" ("up front" or "a priori") are seen to determine the nurse´s account and thus *hindering* the nurse to give a *full* account of the patient´s situation in the sense of missing its history, evolvement, and so on; that is, an account of the nurse´s recognition of the patient´s situation obtained in this way, is *not* assumed, by Benner et al, to correspond with the full situation of the patient. This distinction between a "logico-scientific" and a "narrative" mode of inquiry hints, I argue, at the difference between theories of knowledge presupposing a

cognitive or a non-cognitive principle as the condition of interpreting recognition. This argument I will support with the way Benner and Wrubel (1989) differentiate Husserl from Heidegger.

Husserl´s "view of the person" contains "still", in the opinion of Benner and Wrubel, "Cartesian elements" (1989:42). They specify the "Cartesian elements" of Husserl´s view as follows:

> Husserl´s *noema* (an abstract mental structure that accounts for the mind´s directedness towards objects) is a *cognitive,* representational view of the mind (Benner and Wrubel, 1989:42; emphasis mine).

Benner and Wrubel are implying here, I suggest, that Husserl "still" presupposes a cognitive principle as the condition of interpreting the person´s recognition of objects, for example, a person, and retains, in this way, "Cartesian elements".

Significantly, Husserl is distinguished from Heidegger, according to whom Benner and Wrubel write: "the person grasps the situation *directly* in terms of its meaning for the self" (1989:42). The meaning the situation has for the person is directly recognized. So how is this direct grasp accomplished?

Benner and Wrubel explain further: "The person does not assign meanings to the situation *once* it is apprehended because the *very act* of apprehension is based on taken-for-granted meanings embedded in skills, practices and language" (1989:42; emphasis mine). The person´s apprehension of the situation is understood to be direct, because the person´s apprehension ´in the act´ is based on the person´s "taken-for-granted meanings embedded in skills, practices and language".

In this context it is crucial to know that Heidegger seeks a view of knowledge that is different from the logocentric tradition. His investigation of knowledge no longer has a

cognitive principle as the precondition of explaining the person´s recognition. The origin of the person´s knowledge remains, for Heidegger (1968), a "mystery". In this sense, Heidegger´s theory of knowledge can be considered as a non-cognitive interpretation of recognition.

On this account, it can be said that Benner and Wrubel connect a direct grasp of the person´s recognition with Heidegger´s non-cognitive theory of knowledge. It seems that, for them, the ´loss´ of a cognitive principle enables the person to recognize the situation directly in the sense of corresponding with the situation recognized.

In *Expertise in Nursing Practice* Benner et al note that the "particular hermeneutic tradition within which we worked derives from the phenomenological work of *Heidegger* (1926/1962) and Kierkegaard (1843/1985)" (1996:351; emphasis mine). Since Benner et al connect the "narrative" mode of inquiry as one that enables the nurses to give a full account of the situation, that is, one that is corresponding with the situation talked about, I argue, that Benner et al equate their "narrative" mode of inquiry with a non-cognitive theory of knowledge, such as Heidegger´s.

I argue, moreover, that Benner et al link cognitive theories of knowledge with the "logico-scientific" mode of inquiry. This mode, as noted earlier, is not seen, by them, to enable the nurse to give a full account; that is, one that is *not* corresponding with the situation of the patient.

Benner et al appear to take cognitive principles ("logico-scientific" mode of inquiry) to come between the nurse´s account and the situation of the patient talked about and, therefore, the nurse´s account is not considered to grasp the situation of the patient directly in the sense of corresponding with it; while a non-cognitive principle (a "narrative" mode of inquiry) is seen, I think, to somehow enable the nurse to narrate the situation of the patient fully and, therefore, the nurse´s account is considered to correspond with it.

The nub of this discussion is that I propose that Benner et al (1996) are of the opinion that the nurse's narrative account ("narrative" mode of inquiry), that is, the nurse's account of her recognition of a situation, is seen to *enact* a non-cognitive theory of knowledge; while the nurse's account given in response to terms set up in "advance" ("logico-scientific" mode of inquiry), that is, her recognition of the situation of the patient of which she gives account of by responding, for example, to particular questions (terms set up in "advance"), *enacts* a cognitive theory of knowledge. In short, Benner et al consider cognitive and non-cognitive theories of knowledge to be *descriptions* of the nurse's recognition.

Inversion of Claims

On the view that theories of knowledge are *interpretations* rather than descriptions of the person's recognition of objects in the world which raise particular claims about them means that Benner et al invert those claims.

Benner et al are not accepting the claim about a correspondence between the person's recognition and the object recognized as put forward by cognitive theories of knowledge with regard to a "logico-scientific" way of inquiry which is, for Benner et al, the nurse's account given in response to terms set up in "advance".

This means that Benner et al are not acknowledging the claim about the *uncertainty* of that correspondence as non-cognitive interpretations, like Heidegger's and, following him, Derrida's, assume to have revealed with regard to their "narrative" way of inquiry which is, for them, the nurse's narrative account that is apparently corresponding with the situation of the patient narrated.
If one accepts that theories of knowledge are interpretations rather than descriptions, Benner et al's study of the nurse's skill acquisition involves the contradiction that their study of advanced beginner nurses' narrative accounts, which assumes that those

accounts correspond with the situation of the patient narrated, is considered to reveal that the advanced beginner nurse´s recognition informed by her theoretical knowledge from nursing school is *not* corresponding with the situation of the patient.

Benner et al´s *raison d´être*

However, since Benner et al assert that the advanced beginner nurse´s recognition informed by her theoretical knowledge is not corresponding with the situation of the patient, and since, for them, cognitive theories of knowledge describe the nurse´s recognition as ´not corresponding´, Benner et al imply that, from their point of view, cognitive theories of knowledge describe the advanced beginner nurse´s recognition and theoretical knowledge from nursing school in a concrete sense.

This understanding of theories of knowledge as descriptions rather than interpretations is their *raison d´être* for rejecting the claim about a correspondence between person and object as raised by cognitive interpretations of recognition with regard to the advanced beginner nurse´s recognition and theoretical knowledge. This rejection is in turn the *raison d´être* for their conception about an advance in the nurse´s recognition from the advanced beginner stage to expertise.

On the other hand, a view that holds theories of knowledge to be interpretations instead of descriptions, discloses how Benner et al´s conception about a progression in the nurse´s recognition from advanced beginner stage to expertise presupposes a cognitive principle. That is, Benner et al exchange one cognitive principle, for example, Husserl´s *noema* (Benner and Wrubel, 1989) for another cognitive principle: the development of the nurse´s "skills of seeing" and practical knowledge. This assertion I will discuss next.

CHAPTER SIX

DEVELOPMENT OF PRACTICAL KNOWLEDGE

Introduction

Benner et al demonstrate with their rendering of a "Cartesian view" how theories of knowledge which have a cognitive principle as the condition of interpreting recognition are, for them, descriptions of the person's recognition. Benner et al take the subject (cognitive principle) to be separate from the world, whereby this separate subject establishes "similarities and differences" with the world upon an "objective disengaged criterial" recognition. They write:

> A Cartesian view of the subject as a private separate subject representing and interpreting an objective world seeks to establish similarities and differences *based upon objective disengaged criterial reasoning* (Benner & Wrubel, 1989; Dreyfus, 1979, 1991) (Benner et al, 1996:115-116; emphasis mine).

Benner et al, I argue, connect an "objective disengaged criterial" recognition with theories of knowledge with a cognitive principle. These cognitive theories of knowledge are circumscribed by Benner et al as a "Cartesian view". Benner et al's idea is that a "Cartesian view" literally characterizes the person's recognition as "objective disengaged criterial". The implication of this recognition, Benner et al bring out in their presentation of the nurse's recognition by "cognitivists".

According to Benner et al, cognitivists regard the nurse's recognition as an "intellectual process" in which the nurse matches "internal representations" with "external events" (1996). In relation with a particular example, Benner et al describe the process of an intellectual recognition. They write that "a cognitivist would claim that the nurse carried around in her head internal

representations of 'fragileness,' and simply matched the cues present in the external situation with the features of the internal representation" (Benner et al, 1996:9). *Nota bene*: in their explanation of a "claim" by a cognitivist, the nurse's intellectual process of matching her knowledge of "fragileness" with an entity begins *ex post facto* with a recognition of an entity in the situation as "cues".

The "claim" of a cognitivist, Benner et al define, I argue, according to *their* rendering of a "Cartesian view" (cognitive theories of knowledge) which describes the person's recognition to be "objective, disengaged, criterial". That is, the nurse who "simply" matches the "features" of her "internal representation" of 'cues' with the "cues" she has observed in the "external situation", recognizes the "cues" in that situation of the patient in an "objective, disengaged, criterial" way.

The trouble with the "interpretation" of the person's recognition by a cognitivist (that is, the "interpretation" as defined by Benner et al's understanding of a "Cartesian view" as just indicated) is that "it does not account for what shows up as salient in the particular situation, how the nurse even notices relevant aspects" (Benner et al, 1996:9). The nurse's recognition of what is important in the situation of the patient is not seen to correspond with what is important in the situation of the patient. That is, the nurse's "objective disengaged criterial" recognition is not picking up what is important in the particular situation of the patient; or, the "features" of the nurse's "internal representation" of 'cues' which she "simply" matches with the "cues" in the situation of the patient she has recognized are not considered to correspond with the "cues" in the situation of the patient.

The implication of the nurse's "objective disengaged criterial" recognition of the situation of the patient in her everyday work, then, is that, for Benner et al, there is no correspondence between the nurse's recognition and the situation of the patient recognized.

That there is no correspondence between the nurse´s recognition and the situation of the patient, Benner et al associate also with theoretical knowledge, in particular with the theoretical knowledge of advanced beginner nurses. Benner et al indicate the uncertainty of the advanced beginner nurse´s recognition informed by her theoretical knowledge from nursing school and entities she recognizes in everyday work as follows:

> Much of the perceptual work of advanced beginners is recognizing the concrete manifestations of clinical signs and symptoms. They strive to ´see´ and recognize clinical entities that they have studied only *theoretically*. The concrete reality of conditions like dyspnea, blood reactions, and hypotensive crises become apparent, but recognizing these conditions requires effort of the advanced beginner, particularly when first encountered (1996:51; emphasis mine).

Benner et al, I suggest, equate theoretical knowledge with an "objective disengaged criterial" recognition. That is, they take a "Cartesian view" (cognitive theories of knowledge) to describe the advanced beginner nurse´s recognition and theoretical knowledge in a concrete sense. For them, the advanced beginner nurse´s recognition is informed by theoretical knowledge from nursing school. The implication is that their recognition and knowledge will fail to adequately correspond with the situation of the patient.

And because this is so, advanced beginner nurses are, in the opinion of Benner et al, preoccupied with trying to identify what they see which hinders them to notice that realities, such as "dyspnea" or "blood reactions", appear in different ways and alter their appearance. Benner et al continue the above text: "Engaged as they are by this work of recognition, beginners have less attention available for understanding the ways in which these states vary in their presentation or change over time" (1996:51).

However, if theories of knowledge are interpretations rather than descriptions of recognition, then Benner et al´s notion of an "objective disengaged criterial" recognition does not literally describe the advanced beginner nurse´s recognition and theoretical knowledge, but the claim cognitive theories of knowledge (a "Cartesian view") raise.

Indeed, their understanding of a "Cartesian view" as a description rather than an interpretation of recognition rejects the claim of cognitive theories of knowledge; namely, that the nurse, in matching the "features" of her "internal representation" of ´cues´ with the "cues" in the situation of the patient corresponds with the "cues" she had picked up in the situation. Benner et al decline to acknowledge the claim of cognitive theories of knowledge ("Cartesian view") that the person, in their words, "seeks to establish similarities", that is, a correspondence, with objects in the world (1996:116). In particular, Benner et al reject that the advanced beginner nurse´s recognition sets up "similarities" with the situation of the patient upon her theoretical knowledge from nursing school.

Benner et al refuse to accept what they call the "common sense" of the Western tradition and the discipline of nursing with regard to the advanced beginner nurse´s recognition and theoretical knowledge: "that in order to perceive and relate to things, we have some *content in our minds* that *corresponds* to our knowledge of them" (1996:8; emphasis mine).

Benner et al (1996) seem to have forgotten that the "content" in the mind of nurses is, for Benner (1984), in *From Novice to Expert*, the "precondition" of the nurse´s recognition: "The precondition for perceiving a situation is a foreknowledge or set, and in clinical practice this foreknowledge is often well formed by theory, principles, and prior experience" (1984:8). Significantly, Benner does not distinguish in this particular statement between theoretical knowledge, such as "theory" or "principles", and practical knowledge, such as "prior experience", that

is, the nurse's previous recognition of patients as the precondition of the nurse's recognition in her everyday work.

Benner et al's understanding of theories of knowledge to be descriptions instead of interpretations allows them to ignore, I suggest further, that Benner (1984) explains in *From Novice to Expert* the uncertainty of the nurse's recognition as informed by her knowledge. She writes: "Heidegger (1962) and Gadamer (1975) define experience as the turning around of preconceptions that are *not* confirmed by the actual situation" (Benner, 1984:8; emphasis mine). The person's experience, that is, the person's recognition of the actual situation is for Heidegger (and Gadamer, but I am not concerned with his particular interpretation here) uncertain in that the person's preconceptions, for example, "theory", "principles", or "prior experience" (Benner, 1984:8) are turned around.

The nurse's recognition of the situation of the patient in her everyday work on the basis of her knowledge whether acquired in nursing school or developed in her everyday work is not "confirmed by the actual situation" (Benner, 1984), because Heidegger posits not any longer a cognitive principle as a precondition of claiming a correspondence ("similarities") between the nurse's knowledge and the actual situation (see Chapter Five).

Benner et al (1996) have a point, however, when they state that according to a "Cartesian view" (cognitive theories of knowledge) the person seeks to establish "similarities" and "differences" with objects in the world. Or, when they demand that the nurse "must" understand "commonalities" and "distinctions" with the situation of the patient (Benner et al, 1996:116).

It is only necessary to understand that Benner et al's rendering of a "Cartesian view" according to which the person attempts to recognize "similarities" and "differences" with objects in the world; or, their demand that the nurse "must" recognize "commonalities" and

"distinctions" with the situation of the patient, denotes an interpretation of recognition as put forward by non-cognitive theories of knowledge. A non-cognitive theory of knowledge, for example, Heidegger´s or Derrida´s, explains how the nurse´s recognition, in establishing a correspondence, that is, "commonalities" with the situation of the patient upon her knowledge, effects "distinctions"; that is, as will be explained below, the nurse´s practical knowledge in her everyday work.

On this account, I want to show, first, how Benner et al reject the claim of cognitive theories of knowledge about a correspondence ("commonalities") between the advanced beginner nurse´s recognition and the situation of the patient.

I elucidate, second, how Benner et al´s explanation of the nurse´s development of "skills of seeing" and practical knowledge constitutes a cognitive principle from which their assertion about a correspondence ("commonalities") between the nurse´s recognition and the situation of the patient at the proficient and expert stage is derived. Third, I illustrate Benner et al´s assertion concerning the certainty of the nurse´s recognition at those stages.

I discuss, fourth, how the nurse´s recognition produces, in establishing "commonalities" (correspondence) with the situation of the patient, "distinctions", that is, the nurse´s practical knowledge in her everyday work. I point out that a non-cognitive interpretation of recognition undermines the very idea of the nurse´s development of practical knowledge as the condition of an advance from an "objective, disengaged, criterial" (not corresponding) to an "engaged" (corresponding) recognition.

Correspondence Rejected

Here is an example where Benner et al *imply* a correspondence ("commonalities") between the advanced beginner nurse´s knowledge of "norms and procedures" as

the precondition of her recognition of the situation of patients in her everyday work:

> *Seen through the perceptual net of norms and procedures of care*, patients actually appear to advanced beginners as perplexing collections of problems and conditions for action (1996:49; emphasis mine).

The advanced beginner nurse's recognition informed by "norms and procedures" establishes "commonalities" (correspondence) with the situation as "norms and procedures".

Yet in the opinion of Benner et al, seeing the patient in terms of "norms and procedures" means not attending to the "patient as a person", that is, the advanced beginner nurse's recognition based on "norms and procedure" does not correspond with the "patient as a person". They continue the above quote: "Particularly when the clinical situation is complex, beginners have minimal capacity to attend to the patient as a person" (Benner et al, 1996:49). (See Chapters Nine and Ten for discussion on "patient as a person").

And here is an example where Benner et al state implicitly a correspondence between the knowledge of advanced beginner nurses and their practice. They write: "It seems that the system demands for monitoring standards sets the standard of care for many advanced beginners" (1996:61). Benner et al are saying that the standards for monitoring the patient which require the nurse, for example, "to note on a flow sheet hourly vital signs, medication flow rates, IV flow rates and so on" (Benner et al, 1996:61) *are* the standards of nursing for many advanced beginners. They note a connection between the advanced beginner nurse's knowledge of standards such as reading hourly vital signs and her practice of reading hourly the vital signs of the patient in her everyday work.

However, the advanced beginner nurse's practice based on her knowledge of standards is not taken to correspond with the particular situation of the patient: "Advanced

beginners organize their work and structure their days according to the demands and requirements that are *external* to the immediate patient care situation" (Benner et al, 1996:61; emphasis mine). The advanced beginner nurse who follows requirements, for example, of reading the patient´s vital signs hourly structures her work, in the view of Benner et al, in terms of knowledge that is not corresponding ("external") with the situation of the patient.

Another example comes from their comment about an account of an advanced beginner nurse. This example is of importance for two reasons. It illustrates, first, how an advanced beginner nurse, in contrast to Benner et al´s observation that "beginners have less attention available *for understanding the ways*" in which realities "change over time" (1996:51; emphasis mine), does recognizes such changes in the situation of the patient; second, how Benner et al make the nurse´s theoretical knowledge as the precondition of her recognition of "commonalities" (correspondence) with the situation of the patient absent by noting what this nurse "learned" from the situation.

Benner et al point out that the nurse had "consistently" cared for the patient after a bone marrow transplant and knew that the patient "turned to his family for support" (1996:53). They note further that the patient was rather ill at the time of the nurse´s report. For example, he was running a temperature between "40 and 41 degrees" (Benner et al, 1996:53).

This is the account of an advanced beginner nurse:

> I was real concerned about what was happening psychosocially. Here we have this kid in this isolated room and he was just turning inward more and more and more, and what we were doing was making him pull more and more inward. And what were we going to do so we didn´t have this psychotic kid on our hands that we created? So that´s what I was trying to figure out (quoted in Benner et al, 1996:53).

Clearly, this nurse has observed changes in the way the child communicates with others and attempts to think of what could be done about it. The nurse links what they "were doing", for example, treating the child under conditions of isolation with the conduct of the child of turning "more and more and more" to himself. For her, it seems to be rather obvious that 'they' were constituting the changing behaviour of the child with a bone marrow transplant in one way or another.

This nurse observes how professional procedures guided by particular knowledge (for example, 'treatment under conditions of isolation') produces the situation of the patient over a period of time. From a cognitive interpretation of recognition, the nurse recognizes "commonalities" between particular knowledge informing professional procedures and the situation of the patient.

This is how Benner et al begin their comment: "Five days later, when the child's fever subsided and he was much less ill, she noted a remarkable improvement in his pattern of relating to staff" (1996:53). Benner et al are noting that the nurse observed changes in the situation of this particular patient. For example, that his temperature went down and that he began to communicate with the staff.

They continue: "From this, the nurse *learned* that physiologic as well as psychologic issues must be taken into account when examining a child's status, and that these can change dramatically in a matter of days" (Benner et al, 1996:53; emphasis mine). On what grounds Benner et al think that the nurse learned from her observation of "what was happening psychosocially" that it is necessary to observe "psychologic" as well as "physiologic" issues is not quite clear to me.

The opposite is the case, I think. The nurse's "concern about what was happening psychosocially" already expresses that she knows how to take the psychosocial and the physiological situation of the patient into account. This in turn would imply that the nurse possesses some

knowledge of psychosocial and physiological issues as the precondition of her observation. The nurse´s knowledge of psychosocial issues helped her, I suggest, to recognize, for example, that what ´they´ "were doing was making him pull more and more inward". The nurse, it can be said, assumes to establish "commonalities" (correspondence) between her knowledge of psychosocial issues and the psychosocial situation of the child.

Next I show how Benner et al explain that the nurse´s recognition at the proficient and expert stage corresponds with the situation of the patient.

Re-constituting a Cognitive Principle

The nurse´s development of practical knowledge depends, in the words of Benner et al, on "concrete first-person experience" (1996:120). It means that the nurse develops her practical knowledge through seeing the patient in everyday practice. Seeing many patients of a specific group, for example, in a surgical intensive care unit, is *required* for the nurse´s "skills of seeing" (Benner et al, 1996:115).

By the time the nurse has reached the proficient level, she has, in the opinion of Benner et al, acquired the "*perceptual ability* to read the situation and respond appropriately" (1996:114; emphasis mine). Reading the situation of the patient ´perceptually´ and responding appropriately is: "seeing a clinical situation in terms of a past clinical situation" (Benner et al, 1996:113); that is, in terms of her "practical" knowledge.
The nurse´s "practical knowledge about patient populations" is what, according to Benner et al, "sets up the possibility for a perceptual grasp and for responding to *rapidly changing situations*" (1996:26; emphasis mine). The nurse´s recognition ("skills of seeing") of the patient in relation with her practical knowledge is now considered to be "engaged" in the sense of capturing changes in the situation of the patient as they unfold. For example, Benner et al write: "the proficient nurse now

has enough direct observation and experience", that is, enough "skills of seeing" and practical knowledge from her observation (experience) of specific groups of patients in everyday practice, "to recognize trends and have strong convictions about whether a patient is deteriorating, improving, or on the road to recovery" (1996:120).

The nurse´s practical knowledge, Benner et al claim further, enables the nurse to know what is important in the situation of the patient: "With experience the nurse notices a shift in his or her *ability* to notice what is important" (1996:129; emphasis mine). This "emerging sense" of the nurse in recognizing what is important in the situation on the basis of her practical knowledge is not "infallible", but, in the view of Benner et al, it is still "a real advance over the earlier undifferentiated dread or worry that a nebulous ´something important´ will be missed" (1996:129).

So the nurse´s recognition advances from an "objective disengaged criterial" (not corresponding) recognition. Rather than recognition being based on theoretical knowledge, which misses changes in the situation of the patient, an "engaged" (corresponding) recognition emerges which is based on practical knowledge. This enables the nurse to notice changes in the patient´s situation. Or, the advance can be described as a progression from the nurse´s intellectual recognition which does not tell her what is important in the situation of the patient to "skills of seeing" which notices what is important in the situation of the patient.

Explaining the nurse´s recognition at the proficient and expert stage in terms of the nurse´s development of "skills of seeing" and practical knowledge, Benner et al conceptualize the *condition* of how the nurse comes to see changes and what is important in the situation of the patient. Benner et al establish a cognitive principle in order to interpret the nurse´s recognition at those stages.

This cognitive principle is the condition of their assertion that the nurse´s recognition at those stages is "engaged", that is, establishing a correspondence ("commonalities") with the situation of the patient. Asserting that the nurse´s recognition at the proficient and expert stage corresponds with the situation of the patient, Benner et al repeat the claim of cognitive theories of knowledge (a "Cartesian view"). This is now explicated.

Correspondence Accepted

The first example I have chosen is an account by a nurse at the expert level. This particular nurse works apparently in an intensive care unit for patients after open heart surgery. She meets the patient´s "family" before the patient has been transferred from the operating room to the unit:

> We had a patient that was in the OR (*operating room*) and I´d gotten word that he had been, I think he´d been in the CCU (cardiac care unit, addition mine) beforehand, had a really poor heart, had a lot of M.I.´s (*heart attacks*), poor ejection fraction ... I was coming on to work that evening and had received word that his familiy was sitting and waiting in our waiting room ... So I thought I´ll go out and meet them which I try to do when it works out that way ... They were like stressed to the max because the minute I walked out they jumped off the chair and - they knew I was coming to talk to them - "How are things going?" So I just introduced myself and explained that we really don´t hear much until they (the patient) actually get up to the unit and just talked about what to expect and that they could come in after an hour or so. Anyway, they proceeded to tell me this whole story about what this poor man had gone through and how it was so rough on him, and how he´d been in CCU and was so sick ... I went back into the unit, the patient came up and sure enough was sick as anything on every drip known to man, ballooned, (*heart assist device*) had a

> real hard time coming off bypass. And as I listened to report and I went into the room and looked at him, I'm thinking 'it's going to be a miracle if this man leaves this hospital alive.' That was the sense I had. So anyway, after I got settled, I went out and had the family come and just tried to give them a sense of what to expect, explained that it sounded like he'd been really sick before surgery and that his recovery was probably going to be very slow, might have difficulty weaning (*from the ventilator*), not to expect things to go too quickly, and know that there was a possibility for complications and that kind of thing. And we just sort of clicked ... we just hit it off or something. It was like they needed - when I went out to talk to them in the lobby before, it was like they were just looking for this release valve and I gave it to them and they seemed to appreciate that, and I think at that point we kind of clicked (quoted in Benner et al, 1996:146-147).

This is a report of a nurse who meets with the family of the patient who is about to be received to her unit after surgery on his heart. The nurse tells the family "what to expect" after the operation while the family talks to her about the situation of the patient before the operation. After this exchange, the nurse returns to the unit, admits the patient, and lets the family come into the unit. The nurse, once more, talks to the family about "what to expect" in the situation of the patient.

Benner et al start their comment as follows: "Here the nurse's clinical grasp includes her understanding of the family's situation" (Benner et al, 1996:147). By claiming that the nurse's "clinical grasp" includes her understanding of the situation of the family, Benner et al take a correspondence of the nurse's understanding (recognition) with the family's situation for granted.

This means, for example, that the nurse, when going out to speak to the family of the patient and asserts that the family "were like stressed to the max *because* the minute I walked out they jumped off the chair" (emphasis mine)

grasped, in the opinion of Benner et al, what the family was *really* feeling, namely, "like stressed to the max".

From the view of a cognitive interpretation, the nurse´s recognition is informed by *her* knowledge. The nurse, according to her own report, intended ("So I thought I´ll go out and meet them") to talk to the family of the patient she had heard to be "sitting and waiting in our waiting room". She had also information about the condition of this patient´s heart, that it was "really poor", had had "a lot of M.I.´s (*heart attack*)", and a "poor ejection fraction". She had also learned that the patient, in her words, "I think he´d been in the CCU" (cardiac care unit) before the operation.

Considering her knowledge about the patient´s heart and his stay in the cardiac care unit prior to the operation, it would only be reasonable on her part to expect that his family is to some degree under stress. So going out to meet them, she recognizes people, she very likely had not seen before, getting on their feet. This gesture is interpreted by her as the familiy "were like stressed to the max". She expects them to be stressed so she sees them to be stressed and, therefore, she knows that they are stressed. Her recognition of the family corresponds with her expectation.

Similarly, the nurse´s assertion that the family "knew I was coming to talk to them" the moment she walked into the waiting room, can be considered as a statement that corresponds with the the nurse´s intention. She intended to talk to the family. Seeing the family getting on their feet, she is apparently of the opinion that the family "knew" that she intended to talk to them; as if she had read their thoughts about her intention.

From a cognitive interpretation of recognition, the nurse can be certain about her interpretation of the family´s gesture getting up from "the chair", since it corresponds with her expectation and intention. But can this view be sustained? Has the nurse no reasons to doubt. For example, might the family not have been expecting one of the

surgeons come through the door and answer their question "How are things going?"

At the end of her report she appears to be less certain about her understanding of the situation of the family. This is indicated by statements such as "It was like they needed", "it was like they were just looking" for a release valve, or, "they seemed to appreciate" that she was giving this release valve to them.

Benner et al explain the nurse´s "clinical grasp" further. They write: "Through experience, she knows what to expect in this patient´s recovery" (Benner et al, 1996:147). On the basis of her knowledge, the nurse knows the perspective of the situation of "this" patient after the operation. The nurse´s knowledge defines the perspective of this patient, consequently, the perspective of this patient corresponds with the nurse´s knowledge.

When the family asks the nurse, "How are things going?", she replies that they really do not hear "much" until the patient arrives at the unit. Having admitted that she does not receive a lot of information about the patient while still in the operating room, the nurse, nonetheless, goes on and tells the family "what to expect". The nurse does not need to have *seen* the patient nor does she need to have heard about the patient in the operating room in order to know what to expect and share her expectations about the patient with the family.

The nurse´s knowledge, for example, from nursing school and the knowledge she has gained from more than five years of practicing nursing including what she did hear about this patient´s "really poor heart", is the precondition of talking to the family about the perspective of *this* patient *after* the operation. As Benner et al note, the nurse gives "this projection", that is, what she knows to expect on the basis of her knowledge, "to the family so they can have a sense of what the patient will look like and what the likely events will be" (1996:147).

Benner et al are underlining here the importance of knowledge as the *precondition* of recognition. Without information from the nurse, the family would not quite know what they are looking at when they get the chance to see the patient with "every drip known to man" and "ballooned", that is, connected to a pump assisting the patient´s heart function.

The information the nurse receives during "report" includes the patient´s situation before surgery, because the nurse tells the family later "that it sounded like he´s been really sick before surgery". The nurse also hears, for example, that the patient had "had a real hard time coming off bypass".

After the nurse has listened "to report", she recognizes the situation of the patient in terms of her ´total´ knowledge. She says: "I went into the room and looked at him, I´m thinking ´it´s going to be a miracle if this man leaves this hospital alive´". The nurse establishes a correspondence between her knowledge about a seriously ill patient and the situation of the patient as seriously ill. This nurse, I suggest, assumes her assessment of the patient to represent the situation of the patient.

Concerning the possibility of this patient to recover and leave the hospital "alive", the nurse invokes a "miracle". To put it differently, the nurse is rather certain that the patient is going to die.

Nurses who have advanced, in the opinion of Benner et al, from the earlier stages of advanced beginner and competency to proficiency are seen to have "strong convictions" about "trends" in the situation of the patient (Benner et al, 1996:120). Benner et al describe these strong convictions of nurses about trends in the situation of the patient past the competent stage also as a "new confidence" (1996:121).

My aim is to show with an example that Benner et al´s assertion about a "new confidence" nurses have with regard to trends in the situation of the patient is the *old*

certainty about a correspondence between the person´s knowledge and the object as claimed by cognitive theories of knowledge. The example comes from a "neonatal ICU nurse" (nurse working in an intensive care unit for new born babies; addition mine) at the proficient stage.

This is the nurse´s account:

> Oh, of course he´s going to make it. He´s getting better every day. He´s gaining weight. His heart and lungs do not sound as good as they should. He has to have the facial CPAP every 4 hours to open up the alveoli because they clamp down because he doesn´t have any surfactants to keep them open, but he´s strong. He´ll probably be okay (quoted in Benner et al, 1996:121).

This nurse has observed that the baby is "gaining weight". The nurse appears to be certain that her knowledge of ´gaining weight of babies´ corresponds with how this baby is picking up "weight".

This certainty about a correspondence ("commonalities") between her knowledge and the situation of the patient implies, for Benner et al, I suggest, that the nurse is able to sustain this correspondence, that is, that the baby is "gaining weight" over a period of time. This is evident in their statement about the nurse´s "confidence" about this baby´s recovery; that is, the trend in his situation. They write: "This level of confidence is possible because the nurse has seen other babies with this degree of illness *recover*" (Benner et al, 1996:121; emphasis mine). The implication being that the nurse who sustains a correspondence between her knowledge of ´gaining weight of babies´ and this baby´s "weight" over a period of time, determines the recovery (trend) of the baby.

How the nurse´s knowledge determines the trend in the situation of the patient is emphasized by Benner et al in the last sentence of their comment: "Recognizing trends is the harbinger of the expert level of performance where current actions are guided by the perspective about the

patient's future trajectory" (1996:121). The nurse's knowledge at the expert level determines her "perspective", that is, the trend ("future trajectory") of the patient's situation, in that the nurse's knowledge informs her recognition of the situation of the patient and "current actions".

For example, in the above account, the nurse fails to establish a correspondence between her knowledge of how 'good heart and lungs of babies should sound' and the 'sounds' of this baby. So the nurse's knowledge of how 'good heart and lungs of babies should sound', I argue, informs her current action. She names a particular procedure ("he has to have the facial CPAP every 4 hours") in order to achieve a correspondence ("commonalities") between her knowledge of how 'good heart and lungs of babies should sound' and the sounds of this baby's heart and lungs. That is, the nurse's knowledge informing her recognition and subsequent action determines the trend of this baby (that his heart and lungs sound as "good as they should"). She appears to have strong convictions ("confidence") about it. She says: "he's strong. He'll probably be okay".

The "harbinger" of the nurse's practice at the proficient and expert stage is her certainty about being able to achieve a correspondence between her recognition and the situation of the patient and between her action and the situation of the patient over time, thereby determining the trend in the situation of the patient. That is, the "new confidence" Benner et al ascribe to nurses at the proficient and expert stage about trends in the situation of the patient is the old certainty of the claim raised by cognitive theories of knowledge about a correspondence between person and object.

The Nurse's Recognition Effecting "distinctions"

On the other hand, the nurse's recognition that the baby's heart and lungs do not sound as "good as they should" exemplifies, I suggest, the claim of non-cognitive

theories of knowledge. The nurse´s recognition informed by her knowledge of how ´good heart and lungs of babies should sound´ produces, in establishing "commonalities" with the sounds of the baby´s heart and lungs, "distinctions" (the baby´s heart and lungs are not sounding as "good as they should"), that is, her practical knowledge.

A non-cognitive interpretation explains, then, how the nurse´s recognition in everyday work produces practical knowledge ("distinctions"). But, importantly, the nurse´s practical knowledge, understood as an effect of her recognition, is only added to the knowledge in the nurse´s mind as the precondition of her next recognition.

This is brought out by an account of a nurse who practices, according to Benner et al (1996), at the competent stage (between the stage of advanced beginner and proficiency). The nurse is asked by the interviewer about the "usefulness" of a checklist from "the heart course" (Benner et al, 1996:100). The nurse responds:

> They do present it in the heart course, but it´s still, different things happen with different patients, so it´s not *exactly* as the heart course presents it. Every patient is a little bit different. So, it´s not always, as easy as going down the list and saying this and this and this, no, you have to sometimes consider other factors. But they did present a list. A sort of list, but it´s not always that easy. Plus, understanding the concepts of preload and afterload, that doesn´t come from - you don´t understand that for a while (quoted in Benner et al, 1996:100; emphasis mine).

The nurse´s knowledge such as the "checklist" from the heart course fails to set up an exact correspondence ("commonalities") with the actual situation of the patient, because, in her opinion, with *every* patient "different things happen". It means for this nurse that sometimes "other" aspects than those mentioned on the

checklist from the heart course must be taken into account.

The other aspects ("distinctions") which are different from the nurse´s knowledge, such as the "checklist" from the heart course, are produced through the nurse´s recognition while establishing a correspondence with the actual situation of the patient. These "distinctions" (practical knowledge) extend her knowledge about patients with ´heart conditions´. But the nurse´s next recognition of a patient with a heart condition effects again "distinctions" (practical knowledge). Indeed, *every* recognition of the actual situation of the patient by the nurse produces practical knowledge ("distinctions").

A non-cognitive interpretation of recognition would contradict any notion of the nurse´s practical knowledge being "accumulated" over time, or to be a "form of knowledge in its own right" (Benner et al, 1996:XV). Instead, it undermines Benner et al´s conception of the nurse´s development of "skills of seeing" and practical knowledge. It dissolves practical knowledge as the condition of asserting an advance in the nurse´s recognition from an "objective disengaged criterial" (not corresponding) way to an "engaged" (corresponding) way of recognizing in terms of stages from an advanced beginner level to expertise.

CHAPTER SEVEN

MUTUALITY OF EMOTIONS AND KNOWLEDGE

Introduction

In the previous chapter I have discussed the understanding Benner et al have of a "Cartesian view". They take theories of knowledge with a cognitive principle to describe the person´s recognition to be "objective, disengaged, criterial". In particular, the advanced beginner nurse´s recognition informed by her theoretical knowledge from nursing school is considered to be "objective, disengaged, criterial". The implication is that their recognition does not correspond with the situation of the patient.

On their understanding that theories of knowledge are descriptions rather than interpretations of the person´s recognition, Benner et al are, moreover, of the opinion that theories of knowledge with a cognitive principle separate the person´s emotions and knowledge in a concrete sense and that this separation entails, for them, a distrust in "emotional language". Benner et al write that: "Emotional language is distrusted in our Cartesian legacy *of separating emotion from thinking and knowing* (Benner & Wrubel, 1989; Vetlesen, 1994)" (1996:119; emphasis mine).

Benner et al are, in particular, of the opinion that "our Cartesian legacy" (cognitive theories of knowledge) separates the advanced beginner nurses emotions and theoretical knowledge in a concrete way. This can be illustrated with their statement that the "Cartesian perspective" (that is, a "Cartesian view"; that is, cognitive theories of knowledge) is not so "inaccurate" for advanced beginner nurses, "whose emotional responses are likely to reflect a pervasive mood of fear and anxiety about the unknown or their awkward performance capacity"(Benner et al, 1996:119). Advanced beginner nurses´ emotions, defined as general fear and anxiety, are

seen to interfere with their practice: "advanced beginners´ practice can be impeded by their considerable anxiety about knowledge or performance" (Benner et al, 1996:88).

Claiming, moreover, that advanced beginner nurses´ emotions in terms of anxiety are a "perceptual impediment" (1996:89), that is, a hindrance to their recognition, emotions and theoretical knowledge of advanced beginner nurses are, in the opinion of Benner et al, I suggest, not mutually constitutive. That is, Benner et al separate, in accordance with their rendering of "our Cartesian legacy", the advanced beginner nurse´s emotions from her theoretical knowledge.

Against "our Cartesian legacy" of separating emotion from knowledge, Benner et al hold that "knowledge and emotion are mutually constitutive" (1996:8). Behind this claim about a mutuality of knowledge and emotion is their conception about an advance in the nurse´s recognition from the stages of advanced beginner and competency to proficiency and expertise. The nurse´s recognition of the situation of the patient at the former stages, particularly at the advanced beginner stage, is, for Benner et al, based on her theoretical knowledge. At the stages of proficiency and expertise, the nurse´s recognition is her "skills of seeing" based on her practical knowledge.

Integral to the development of the nurse´s "skills of seeing" and her practical knowledge in everyday work are, according to Benner et al, the nurse´s emotions. The nurse´s emotions are seen to become one "source" of the nurse´s "perceptual awareness" from the competent stage onwards (Benner et al, 1996:89). The nurse´s emotions are considered to sharpen the nurse´s recognition and to guide the development of practical knowledge until she has ´sufficient´ "skills of seeing" and practical knowledge to make a "qualitative leap" from competency to proficiency.

When Benner et al, therefore, state that "knowledge and emotion are mutually constitutive" (1996:8), it means

that, in their conception about an advance in the nurse´s recognition, the nurse´s emotions and practical knowledge *become* mutually constitutive, that is, the mutuality of the nurse´s practical knowledge and emotions becomes the condition of the development of her recognition as "skills of seeing" and practical knowledge.

Explaining the condition of an advance in the nurse´s recognition in terms of the nurse´s practical knowledge and emotions coming together over time, Benner et al view their own conception to represent, in a concrete sense, the advance in the nurse´s recognition. Benner et al believe that the nurse´s emotions as they begin to ´kick in´ after the advanced beginner stage add some quality to the nurse´s recognition of the situation of the patient and, this being so, turn her recognition into "skills of seeing" and her theoretical knowledge into practical knowledge that is "qualitatively" different than her recognition based on theoretical knowledge.

To recapture the discussion at this point: "our Cartesian legacy" describes, for Benner et al, a separation between the person´s emotions and knowledge in a concrete sense. This rendering has, I argue, two implications. One, Benner et al consider the advanced beginner nurse´s emotions to be separate from her theoretical knowledge. Two, they view their conception about an advance in the nurse´s recognition to explain the coming together of the nurse´s emotions and practical knowledge as the condition of her recognition at the proficient and expert stage in a concrete sense.

The statement of Benner et al about "our Cartesian legacy" of separating emotion from knowledge is referenced with Vetlesen (1994). In order to support the view that theories of knowledge are interpretations instead of descriptions, I wish in this chapter to scrutinize, first, the validity of this reference to Vetlesen. I want to clarify that the understanding of Benner et al of "our Cartesian legacy" is not Vetlesen´s. In particular, that Benner et al´s separating of emotions from knowledge in a concrete sense and, therefore, the need for emotions and

knowledge having to come together through recognitions in everyday life is absent from Vetlesen´s theory of moral perception. Instead, I will suggest that Vetlesen assumes a mutuality of the person´s emotions and knowledge as a ´givenness´ of human beings.

Benner et al´s understanding of "our Cartesian legacy" of separating the person´s knowledge and emotions entails, as noted at the beginning of the chapter, a distrust in "emotional language". Since Benner et al conceive the advanced beginner nurse´s emotions and theoretical knowledge to be separate, it is reasonable to argue that Benner et al distrust the "emotional language" of advanced beginner nurses. This argument I want to support by explicating, second, how Benner et al are refusing to acknowledge the advanced beginner nurse´s mutuality of emotions and knowledge as displayed in their language.

Third, I will show in this chapter, how Benner et al trust the "emotional language" of nurses from the competent stage onwards. Their language reveals, to them, the mutuality of the nurse´s emotions and practical knowledge. I point out that Benner et al´s description of the nurse´s recognition on the basis of the mutuality of her emotions and practical knowledge adds the nurse´s emotions to their ´essential´ principle which explains the advance in the nurse´s recognition: the nurse´s development of "skills of seeing" and practical knowledge through her recognitions in everyday work (see Chapter Six).

Fourth, I explicate how Benner et al assert that the nurse´s recognition of "commonalities" and "distinctions" at the proficient and expert stage corresponds with the situation of the patient. According to them, this correspondence is possible *because* the nurse´s recognition as based on her "skills of seeing" and practical knowledge (that is, the nurse´s emotions and practical knowledge having become mutually constitutive) at those stages is "qualitatively" different from the nurse´s recognition at the earlier stages. On the view that their explanation is a cognitive conception, Benner et al repeat the claim

about a correspondence between person and object of cognitive theories of knowledge.

I discuss, fifth, how Benner et al convert the nurse´s development of practical knowledge into the development of her ethical knowledge by correlating the nurse´s recognition of "commonalities" and "distinctions" respectively with notions of good and not good.

I demonstrate, finally, with an example, how the nurse´s recognition of "commonalities" effects "distinctions"; that is, how Benner et al´s demand that the nurse must recognize "commonalities" and "distinctions" with the situation of the patient supports a non-cognitive interpretation of recognition. In this context, I show further how their correlation of good and not good with the nurse´s recognition of "commonalities" and "distinctions" does not work.

Vetlesen´s Theory of Moral Perception

In his discussion about moral perception, Vetlesen, following Heidegger, speaks of the person´s human receptivity as "the primordial capacity of human beings to be attentive to, to be alert to" (1994:162). Vetlesen claims that empathy which lies at the "bottom" of humankind´s emotional faculty makes the person perceive a situation as one where another person´s "weal and woe" is at stake. The faculty of empathy allows the person to become aware of the other person who may be in a situation of suffering "without sharing" the other´s feeling in the sense of experiencing it himself or herself.

Empathy "anchors" the person to the other´s emotional experience. The point Vetlesen wants to make is that such receptivity/attentiveness, "is something *active*, not passive"; yet it is not something the person brings "selfconsciously" about (1994:17; emphasis in the original). It is empathy that establishes an "emotional bond" between the person and the other. And it is because of this emotional bond that the person is able to put

himself or herself "in" the place of the other by way of "feeling-into and feeling-with" (Vetlesen, 1994:8).

Vetlesen further contends that empathy "contains" a cognitive dimension corresponding to the faculty of representative thinking. Representative thinking is in his theory the "basic" cognitive faculty required for the exercise of moral judgement. It is the mental process of making the "standpoints of those who are absent" - present to the person´s mind (Vetlesen, 1994:105). It is by virtue of the person´s cognitive dimension that empathy "and it alone, discloses to us something about another person - namely, his or her emotional experience in a given situation" (Vetlesen, 1994:204). In a word, Vetlesen conceptualizes the person´s ability to perceive (knowledge) and to feel (emotion) as empathy *containing* cognition.

Vetlesen´s theory of moral perception, I suggest, assumes a mutuality of the person´s emotions and knowledge as a ´givenness´ of human beings which he conceives in a particular way. If one takes a mutuality of the person´s emotions and knowledge as a ´givenness´, then, I claim, that the nurse´s "emotional language" (Benner et al, 1996) will reveal such mutuality of emotions and knowledge.

However, since Benner et al separate the advanced beginner nurse´s emotions from her theoretical knowledge in accordance with their understanding of "our Cartesian legacy" which entails, for them, a distrust in "emotional language", it implies, I suggest, that Benner et al distrust the "emotional language" of advanced beginner nurses; that is, the mutuality of advanced beginner nurses´ emotions and theoretical knowledge as articulated in their language.

Emotional Language of Advanced Beginner Nurses

With a number of examples from advanced beginner nurses in *Expertise in Nursing Practice* I wish to support my claim about a ´givenness´ of a mutuality of emotions and

knowledge of human beings. I will begin by showing how Benner et al refuse to acknowledge the mutuality of their emotions and knowledge as expressed in their accounts. Advanced beginner nurses in the study of Benner et al (1996), it is recalled here, have practiced less than a year after their nursing training in critical care nursing:

> Nurse 1: We had Mr. M., this guy who was in liver failure and he was essentially a one-to-one patient. I had him and I had two other patients. And I was like oh, there´s that panic thing when I come in and they´re saying all about the different labs and this IV and that IV, this tube and that tube.
>
> Nurse 2: You get a major rush.
>
> Nurse 1: "WHAT!" The first thing that happens, I feel myself going (takes a big loud breath) like this, my whole body is just tensing.
>
> Nurse 2: And you haven´t even opened the cardex yet.
>
> Nurse 1: Just tensing. And they opened the cardex and there was so much written on there, you can´t even decipher what´s what and I was like this (all tensed up) (quoted in Benner et al, 1996:49).

Unfortunately, neither one of the two nurses nor Benner et al give information about the setting of this account. For example, it is difficult to discern whether their account captures the beginning of a shift which is possibly indicated by the remark of Nurse 2, "you haven´t´ even opened the cardex yet"; or whether Nurse 1 relates her feelings at any time during a shift "when I come in" (to the room of the patient) and "they´re saying" (I take it to be the physicians saying) "all about" different laboratory tests ("labs"), intravenous drips/fluid ("IV") and ´this and that tube´; or, whether this is an account that highlights episodes in everyday practice, such as nurses assessing their work load, physicians discussing diagnostic and treatment, nurses attempting to orientate

themselves about patients by reading "the cardex" and finding it difficult to "decipher what´s what".

What is clear is that Nurse 1 is taking care of three patients, one of whom is Mr. M. According to Nurse 1, Mr. M., who is in "liver failure", already needs a nurse on his own ("essentially a one-to-one patient"), that she hears physicians say all about "labs", IVs, and tubes, and that they open the cardex with "so much written" so that it can hardly be deciphered; and she states her feelings: "that panic thing"; "´What!´ The first thing that happens; I feel myself going (takes a big loud breath) like this; my whole body is just tensing"; " Just tensing"; and "I was like this (all tensed up)".

The language of Nurse 1 shows how her emotions, for example, "that panic thing" contains her knowledge of Mr. M. being "essentially a-one-to-one patient", and "I had two other patients", and the physicians "saying all about the different labs and this IV and that IV, this tube and that tube"; while her language (knowledge), for example, that Mr. M. is "essentially a-one-to-one patient", and "I had two other patients", and the physicians "saying all about the different labs and this IV and that IV, this tube and that tube" contains her emotions: "that panic thing". The nurse´s feelings are inside her knowledge (language) and her knowledge is inside her feelings.

While the account of this advanced beginner nurse reveals the mutuality of the nurse´s emotions and knowledge, Benner et al comment that: "The emotional overlay of this and many advanced beginners´ narratives is one of temporarily incapacitating anxiety" (1996:49). Benner et al are suggesting that advanced beginner nurses´ are *overreacting* emotionally and that such overreaction of emotions, described as "incapacitating" anxiety, hinders their recognition of the situation for an undefined time. Their "emotional overlay", Benner et al appear to be saying here, is in the way of advanced beginner nurses in their progressing towards a "fluid, almost seamless performance" (1996:143) which, for Benner et al, is the hallmark of nurses practicing at the expert stage.

So Benner et al recommend that advanced beginner nurses tone down their emotions of anxiety and fear for their performance to improve: "advanced beginner performance usually will improve by *dampening* anxiety and fear" (1996:119; emphasis mine). Yet they immediately caution such dampening of emotions with regard to the next stages: "But it is a mistake to overgeneralize detachment from emotional responses to *subsequent*" levels of competency, proficiency, and expertise (Benner et al, 1996:119; emphasis mine).

Benner et al are facing a difficulty. Obviously, they are not denying that advanced beginner nurses have emotions. They *only* deny that their emotions and theoretical knowledge are mutually constitutive. This mutuality appears to be taken for granted by advanced beginner nurses themselves as another example by an advanced beginner nurse suggests:

> And I just talked to myself and I had a great night because this was the first time I did it ... I was (saying to myself) "Okay. Just take it one step at a time. You're only human, do one thing then go onto the next thing. It will all get done, it will get done easier if you're calm and because you think better that way" ... And the shift went great" (quoted in Benner et al, 1996:50).

The nurse's thinking ("I just talked to myself ... 'Okay. Just take it one step at a time'", and so on) influcences her emotions ("if you're calm"), and her emotions influence her thinking ("you think better that way"), and such mutuality of thinking (knowledge) and emotions influences her performance ("it will get done easier").

But Benner et al will not allow any mutuality of knowledge and emotions for the advanced beginner nurses. Acknowledging such a a mutuality would compromise their conception about an advance in the nurse's recognition which has a separation of their emotions and theoretical knowledge as its *raison d'être*. So Benner et al have to

find something wrong with advanced beginner nurses´ emotions, such as an "emotional overlay", or with their theoretical knowledge, as I will presently show, in order to sustain their case that theoretical knowledge and emotions are separate and become mutually constitutive from the competent stage onwards.

The next example of an advanced beginner nurse conveys a more positive note. Benner et al inform the reader that: "His entire statement was delivered in an excited, enthusiastic tone" (1996:52). Although this advanced beginner nurse does not employ language, such as ´I was excited´, in his account, Benner et al apparently noticed his emotions in the tone of his statement as being "excited and enthusiastic". Benner et al, I want to propose, while revealing a mutuality of emotions and theoretical knowledge in this advanced beginner nurse´s account cannot bring themselves to see it:

> I had learned so much. There are two clinical nurse specialists involved right now. There are people on the unit who are CNIIs and CNIIIs (very likely ´Critical Care Nurses´ of different grades such as II and III; addition mine) who are just really knowledgeable on major GI surgery (gastro-intestinal surgery, addition mine) on infants. I talked to all these people and pediatric surgery were really helpful, and our attendings and fellows (physicians in particular professional positions, addition mine) were ... I mean, I just learned so much in the last three days, I couldn´t even tell you (quoted in Benner et al, 1996:52).

This advanced beginner nurse has evidently enjoyed learning from "knowledgeable" professionals, for example, nurses and physicians, about surgery on infants. If one assumes that this advanced beginner nurse´s "excited, enthusiastic tone" in which, according to Benner et al, his account about learning "so much" was delivered are an indication of his emotions of excitement and enthusiasm when he was actually learning about surgery on infants, then it is reasonable to say that his emotions

were inside his learning (knowledge) and his learning (knowledge) was inside his emotions.

Indeed, Benner et al could hardly disagree with this point. They write: "Probably *only the beginner* can have this kind of pure pleasure in learning about a new clinical disease or problem" (1996:52; emphasis mine). They are noting here how "pure pleasure" (emotions) links with "learning" (knowledge). So what is to be distrusted about the "pure pleasure in learning" of this advanced beginner nurse?

Benner et al continue: "His comment (and the exemplar that surrounds it) demonstrated an *innocence* that we observed *only* in advanced beginners" (1996:52; emphasis mine). Their general point is that advanced beginner nurses' "innocent and unqualified" learning contrasts with that of nurses at the stages of competency, proficiency, and expertise (Benner et al, 1996:52). Mutuality of theoretical knowledge and emotions of advanced beginner nurses stands no chance, I think, to be acknowledged by Benner et al before they get to the stage of competency.

Next I want to show how *Benner et al* trust the "emotional language" of nurses at the competent stage; that is, how their accounts (language) disclose, for them, the mutuality of the nurse's emotions and practical knowledge.

Adding the Nurse's Emotions

The more generalized feelings of anxiety and fear of advanced beginner nurses' emotions contrast, in the opinion of Benner et al, with the emotions of nurses at the competent stage. At this stage nurses are seen to "begin to talk about how they feel about a situation (comfortable, anxious, unsure, confident) in much more differentiated ways" (Benner et al, 1996:88). Being able to articulate their recognition of a situation of the patient in terms of feeling comfortable, anxious, and so on, indicates that: "competent nurses' emotional responses to a situation *now* give them a *better access* to what is

happening to the patient" (Benner et al 1996:89; emphasis mine). Or, they state further: "As competent practitioners settle more comfortably into their roles, their *emotional responses become more informative and guiding*" (Benner et al, 1996:89; emphasis mine).

In other words, through recognitions of situations of a particular group of patients in everyday work, the emotions of nurses at the competent stage have become involved so that their recognition of the patient´s situation is sharpened and starts to produce "skills of seeing" and practical knowledge which is "qualitatively" different than theoretical knowledge; that is, the separation between theoretical knowledge and emotions characteristic of advanced beginner nurses is gradually overcome. The recognition of the competent nurse is informed by her emerging "skills of seeing" and practical knowledge; that is, the nurse´s recognition after the stage of advanced beginner nurse is asserted to correspond with the situation of the patient.

Benner et al´s explanation of the nurse´s recognition from the comptent stage onwards is now based on the mutuality of the nurse´s emotions and practical knowledge. Benner et al have added, I suggest, the nurse´s emotions to their ´essential´ cognitive principle: the development of the nurse´s "skills of seeing" and practical knowledge which explains an advance in the nurse´s recognition.

I will now explicate how Benner et al reiterate the claim of cognitive theories of knowledge when they assert that the nurse´s recognition of "commonalities" and "distinctions" corresponds with the situation of the patient *because* the nurse´s recognition at the proficient and expert stage is "qualitatively" different from the nurse´s recognition at the advanced beginner stage.

Correspondence Asserted

Benner et al describe how the nurse recognizes "commonalities" (correspondence) with the situation of the patient at the competent stage as follows:

> the nurse has gained the ability to anticipate certain typical progressions in the patient's recovery (1996:78).

They are saying that the nurse who has learned from recognizing many situations of patients that, for example, breathing regularly is a typical sign of the patient's recovery, anticipates to establish a correspondence ("commonalities") between her recognition ("skills of seeing") informed by that particular practical knowledge and the situation of the patient.
However, if the nurse's practical knowledge is developed through her recognition of *many* situations of patients, how can Benner et al assert that this knowledge of many situations of patients enables the nurse to establish a correspondence with a *particular* situation of the patient? Questioning the nurse's recognition of a particular situation when informed by her practical knowledge of many situations of patients would, however, meet with some opposition from Benner et al. They would likely want to suggest that I missed the point about the nurse's emotions and practical knowledge having come together from the competent stage onwards as the condition of a "qualitative leap" in the nurse's recognition between the stages of competency and proficiency.

Because Benner et al assert about the nurse's recognition at the proficient stage that: "It is this ability to read the situation instead of laying on a preconceived set of expectations that makes expert practice possible" (1996:142). Putting a "preconceived set of expectations" over the situation of the patient is, for them, recognizing the situation in terms of theoretical knowledge. In other words, the advanced beginner nurse's recognition based on theoretical knowledge is putting

predetermined knowledge over the situation of the patient (see Introduction).

This is another way in which Benner et al express the idea that the advanced beginner nurse´s recognition informed by her theoretical knowledge is not corresponding with the situation of the patient which implies, for them, a separation between advanced beginner nurses´ theoretical knowledge and emotions.

But since the nurse´s emotions and practical knowledge have, according to Benner et al, become mutually constitutive through the nurse´s recognition of many situations of a particular group of patients in her everyday work, the expert nurse´s recognition ("skills of seeing") informed by her practical knowledge is now "qualitatively" different and thus corresponds with the situation of the patient.

Just in case that their notion of a "qualitative leap" in the nurse´s recognition between competent and proficient/expert stage sounds too far fetched, Benner et al illustrate this advance in the nurse´s recognition with an account about a resuscitation (a procedure to recover the respiratory and heart function) of a patient by an expert nurse. The patient in this situation was, according to Benner et al, haemorrhaging and stopped breathing. This is an excerpt of the nurse´s report:

> I looked at his heart rate and I said: ´O.K. he is bradying down. Someone want to give me some atropine?´ I just started calling out the drugs that I needed to get for this guy, so we started to push these drugs in. In the meantime, I said, ´can we have some more blood?´ I was just barking out this stuff (the things that were needed and had to be done). I can´t even tell you the sequence. I was saying, ´We need this.´ I needed to anticipate what was going to happen and I could do this because I had been through this a week before with this guy and knew what we had done (and what had worked). The anesthesiologist came in and did a good intubation. He asks: ´what kind of (IV)

> lines do we have?´ I said, ´We have a triple lumen and we have blood. All (IV) ports are taken. We need another kind of line. He´s got no veins left. He goes, ´O.K., fine, give me a cut-down tray ... (quoted in: Benner et al, 1996:142-143).

After recognizing that the heart rate was slowing ("bradying") down of a patient who was bleeding and had stopped breathing; that is, after the nurse´s "skills of seeing" and practical knowledge establishes a correspondence ("commonalities") with the situation of the patient in terms of "bradying down", the nurse asks for "atropine" and the "stuff" which, according to Benner et al, was "needed".

For this performance the nurse draws, according to her own account, on knowledge from a previous performance of resuscitating this particular patient. She reports: "I was just barking out this stuff", for example, "drugs" and "blood". Then she describes how she knew which "stuff" she had to call for: "I needed *to anticipate* what was going to happen *and I could do this* because I had been through this a week before with this guy and knew what we had done" (emphasis mine).

For Benner et al this nurse´s ability to "anticipate", that is, her practical knowledge informing her recognition and actions, is not predetermined. Benner et al assure that: "This is not just a rote repetition of the previous resuscitation; rather, her responses are based on the *understanding* gained in the previous situation" (1996:143; emphasis mine). Benner et al are saying, since this is an expert nurse, she has made her "qualitative leap" to proficiency already some years ago, implying that her emotions did ´kick in´ at the competent stage turning her theoretical knowledge into practical knowledge. For them, her emotions and practical knowledge having become mutually constitutive and thus the condition of developing her "skills of seeing" and practical knowledge. Therefore, her calling for the "stuff" needed is not a "rote repetition" of the previous performance or putting, like advanced beginner nurses do, a "preconceived set of

expectations" over the present performance. No, for Benner et al, the expert nurse's recognition of the patient and her subsequent actions are "qualitatively" different from those of an advanced beginner nurse because her recognition and actions are "based" on "understanding", that is, on her "skills of seeing" and practical knowledge.

Consequently, her "skills of seeing" based on her practical knowledge developed over years including that from the "previous situation" enable her to establish a correspondence ("commonalities") with the situation of the patient and because her recognition corresponds with the situation of the patient her actions are corresponding with the situation of the patient.

Importantly, the nurse's recognition ("skills of seeing") informed by her practical knowledge is not only establishing a correspondence with the situation in terms of "commonalities", but also in terms of "distinctions". The nurse's recognition of "distinctions" as corresponding with the situation of the patient begins, for Benner et al, at the competent stage. They state concerning the nurse's recognition at this stage:

> For example, not having a good grasp of the situation, or having the situation seem vaguely off what the nurse has learned to expect, provides guiding and alerting information (Benner et al, 1996:89).

When the nurse's recognition informed by what she "has learned to expect", that is, her practical knowledge, fails to establish a correspondence ("vaguely off") with the situation (or has not a "good grasp" of the situation) then her recognition of the situation "provides guiding and alerting information" about the situation of the patient.

In relation with nurses who have made the "qualitative leap" to the proficient stage, Benner et al reveal more

clearly, how the nurse's recognition ("skills of seeing) informed by her practical knowledge which is not establishing a correspondence ("commonalities") with the situation of the patient is, for Benner et al, nonetheless corresponding with the situation. They write:

> They can now trust that their loss of practical grasp *or* discomfort in a situation is meaningful, i.e., connected to what is occurring *in* the situation (Benner et al, 1996:118; emphasis mine).

The nurse who recognizes meaningful "distinctions" between her practical knowledge informing her recognition and the situation, can now "trust" that her recognition of meaningful "distinctions"/discomfort is "connected" with what is going on "in" the situation. That is, the expert nurse's recognition (informed by her "skills of seeing" and practical knowledge) of "distinctions" in the situation of the patient is corresponding with the "distinctions" in the situation of the patient.

As an aside, Benner et al are having difficulties in expressing the mutuality of the nurse's knowledge (recognition) and her emotions ("discomfort") they want to convey here by speaking of a loss of a meaningful "grasp" *or* "discomfort". Assuming a mutuality between the nurse's emotions and knowledge (which Benner et al do with regard to nurses at the proficient stage, but for the wrong reason as I explained earlier), then the nurse's recognition of a loss of meaningful grasp (knowledge) and her discomfort (emotions) each include the other.

Good and Not Good Ethical Knowledge

Benner et al describe the nurse's recognition of "distinctions" with the situation also as *not* having a "good grasp". A "good grasp" of the situation of the patient, on the other hand, is one when she recognizes "commonalities" with the situation. Benner et al write, for example, that nurses at the competent stage "can talk

about feeling comfortable when they have a good grasp of a situation" (Benner et al, 1996:89).

The importance of Benner et al's move here should not be missed. Correlating the nurse's recognition of "commonalities" and "distinctions" with the situation respectively with notions of good and not good, Benner et al convert the nurse's recognition of the situation of the patient into an ethical recognition in the sense of good or not good and her practical knowledge into ethical knowledge in this sense.

Benner et al discuss the nurse's development of her ethical knowledge by recognizing "commonalities" as good and "distinctions" as not good with an account by a nurse at the competent stage. This nurse illustrates, in the opinion of Benner et al, how nurses' feelings of "disappointment" or "success" depend on practicing *not* "well" or "things" going "well" and that the nurse's recognition of "things" going "well" encourage nurses to be "good" nurses: "When nurses do not perform well they feel varying degrees of disappointment, when things go well, the success is laden with import, giving nurses hope that they can be good nurses. For example" (Benner et al, 1996:90):

> Nurse: I had a good week. I really did. The last (*interview session*) I could not think of anything good at all, it was like: 'Oh, I hate nursing!' I want to get out of here so badly and then this last week I had two nights that went absolutely perfect where I could not have - I just feel good. I could not have done anything better than I did. I was so perfect (laugh). I needed those, didn't I?
>
> Int: Save you from leaving nursing. What does perfect mean to you?
>
> Nurse: Yeah, well but not just where you do all your tasks right, but where you get the art of nursing down to where it just feels like the night went absolutely perfect *for you*; not just good, not just the really nice night but it went great. And I was good ... I don't know. Usually

> there are nights where you don't do anything wrong but there's a lot of things you could have done better. I could have positioned the baby a little better. I could have been brighter at the bedside, just little tiny things that you think, 'Oh, it was good, but there were certain things I could have done better and these nights went perfectly'... It was a good feeling to feel like, I'd put the baby up on her side in a little fetal position and she stayed there. She didn't flail all over the bed (laugh). Just little things really made the night go well. (quoted in Benner et al, 1996:90; emphasis mine).

This nurse cannot help but being pleased about the way the two night duties went for her and how "good" or "perfect" she was. During these nights she was able to perform her tasks more than right, indeed, perfect for her. The nurse, it seems, has some ideas about achieving tasks perfect rather than right, because there are nights when she realizes a difference between her performance and the possibility of performing just "a little bit better".

Her feelings about the two nights going "absolutely perfect" for her indicates, I suggest, that the kind of practice she succeeded to perform corresponds with her ideas of 'absolutely perfect' practice. For example, for her it "was a good feeling to feel" that the baby she put in "a little fetal position" remained in that position ("she stayed there"). The nurse feels good about the baby conforming to her practice by not flailing "all over the bed".

This is how Benner et al begin their comment:

> *Feeling good when performance is good and poorly when things do not go well* provides an emotional guide that sharpens the nurse's perceptual acuity and guides the development of skilled clinical know-how *and* ethical comportment (Benner et al, 1996:90; emphasis mine).

Stating that "Feeling good when performance is good", Benner et al are saying that the nurse's performance, for

example, of putting the baby in "a little fetal position" has been recognized by the nurse as "commonalities" (correspondence) with the situation of the baby who remained in that particular position.

The nurse's recognition of "commonalities" between her performance of putting the patient in a particular position and the position of the patient is, for Benner et al, a good recognition of her performance which brought this position about and, therefore, the performance is good and the nurse feels good.

Noting further that feeling "poorly when things do not go well", Benner et al are implying that if the nurse would have recognized "distinctions" between her performance of putting the baby in "a little fetal position" and the situation in terms of the baby flailing "all over the bed", then such recognition is for Benner et al not good ("poorly") and indicates that "things do not go well". So her performance is poor, (not good) consequently, the nurse feels poorly (not good).

The nurse's recognitions of good "commonalities" and not good (or "poor") "distinctions" are, in the view of Benner et al, the development of "skilled clinical know-how", that is, of practical knowledge "and ethical comportment" (1996:90). The division between practical knowledge and "ethical comportment", Benner et al are making here is, on the foregoing discussion, I suggest, secondary. The nurse's practical knowledge *is* her ethical knowledge ("ethical comportment") in terms of good and not good.

Next I want to show how the nurse's recognition of "commonalities" with the situation of the patient as informed by her practical (ethical) knowledge effects "distinctions" and that, on this view, the correlation of the nurse's recognition of "commonalities" as good and of "distinctions" as not good does not work.

"Distinctions" as an Effect

Benner et al introduce the nurse's account about an infant whose respiratory (heart) arrest was resuscitated, a procedure which in professional parlance is also referred to as "code" by noting that: "In the following example, the nurse enters her first successful code with the experience of having closely observed and recorded several successful infant codes" (1996:81). The account comes from a nurse who is, according to Benner et al, at the competent stage:

> Nurse: ... It would have been better if he hadn't survived and I think in a way I was hoping he wouldn't. So I was a little upset when we got a heart rate back, but at the same time, it was good. It was the first time I had been in a code (*she had discovered the respiratory arrest and initiated the resuscitation*) and for it to be succesful.
>
> Int: You haven't been in the situation where you ...
>
> Nurse: Right. Well I've seen a couple of baby ones that were successful .. but this was one of those 'baptisms by fire' where you are not absolutely sure that you can do it until you're confronted with the situation.
>
> Int: What do you think helps you be ready for it?
>
> Nurse: I think watching. I used to stand back and just watch and I really think before somebody participates, being a recorder is really good because you get to see everything that happens. You have to watch very closely, write it all down, and writing it down helps you remember later what order everything had been done. I had done that a couple of times before and I think that was probably the main thing and also knowing the baby, knowing what he's like, knowing every inch of the back of his neck. He didn't have an IV. Just things like that all added together. But I really think being a recorder was the biggest thing; much better than participating in a mock code in nursing

> school ...(quoted in Benner et al, 1996:81).

This nurse has observed several "successful" codes which had been performed on babies in the past and prepared herself a checklist about the "order" which she found to be inherent in those performances. Through her recognitions of "commonalities", that is, of a correspondence between a practice intended to recover the respiratory and heart functions of patients and those functions being recovered, the nurse developed her practical knowledge. To be ready for a code entails for this nurse remembering the "order" of 'running' a code and knowing the baby, for example, that he did not have an "IV" (intravenous line for adminstering fluids and medication).

In this specific situation, the nurse's recognition informed by her practical knowledge establishes "commonalities" with the situation of the baby in terms of a respiratory arrest. Benner et al take it for granted that the nurse's recognition of a "respiratory arrest" corresponds with the situation of the patient since the nurse's action (according to Benner et al, the nurse "initiated the resuscitation") is seen to be "needed", that is, corresponding with the nurse's recognition of the 'needed' action in situation of the patient. They write: "Practical mastery of the likely sequencing, the nature of the teamwork, and knowing a range of clinical eventualities, in addition to knowing this particular infant allows the nurse *to anticipate and respond to the action needed* (Benner et al, 1996:81; emphasis mine).

But the nurse does not appear as certain as Benner et al about a correspondence between her recognition of the situation of the patient ("respiratory arrest", according to Benner et al) and her action (initiating the resuscitation). Following the nurse, the performance of the resuscitation was, in her word, "good". It had been "the first time" she had "been in a code ... for it to be successful", that is, in establishing a correspondence ("commonalities") between the resuscitation and the

function of the baby's heart: "we got a heart rate back". The nurse indicates here that the baby's heart had arrested.

However, the nurse notices that, "at the same time", she is a "little upset" about this "good" and "successful" resuscitation of the baby's heart function. In her opinion: "It would have been better if he hadn't survived".

The nurse's reflection about a "good" and "successful" resuscitation of the baby's heart exemplifies how a particular performance achieves, *simultaneously*, "commonalities" ("we got a heart rate back") and "distinctions" ("It would have been better if he hadn't survived"). She demonstrates that the demand of Benner et al that the nurse must recognize "commonalities" and "distinctions" in the situation of the patient points to a non-cognitive interpretation of recognition; that the nurse's recognition of "commonalities" produces, inevitably, "distinctions", that is, her practical (ethical) knowledge (see also Chapters Six and Eight).

The nurse's account illustrates also how a performance, such as a resuscitation, which accomplishes *good* "commonalities" between practical knowledge guiding that performance and the situation of the patient effects a situation which the nurse had hoped would not be achieved ("It would have been better if he hadn't survived"). Not succeeding in the resuscitation of the baby's heart function would have entailed, according to Benner et al's correlation of the nurse's recognition of "distinctions" with not good, this nurse's recognition of the situation of the baby as *not good* "distinctions" between her practical (ethical) knowledge guiding that performance (recovering the patient's heart function) and the situation of the patient as *not* having gotten a "heart rate back".

Yet the possibility of recognizing "distinctions" as not good is considered by this nurse to "have been better", that is, good for the patient not to have survived. Her

account allows to suggest that she would have, in a way, felt good if she would have recognized not good "distinctions" between the performance of resuscitating the baby´s heart and the situation of the baby as *not* having gotten a "heart rate back". The nurse illuminates the possibility that a good performance, understood as achieving a correspondence ("commonalities") with the situation of the patient, effects "distinctions" which may be, from the nurse´s perspective, good or not good.

So the maxim of Benner et al that ´nurses feel good when performance is good´ and that they ´feel not good when performance is not good´ appears to be rather uncertain. This uncertainty of the nurse´s recognition of "commonalities" as ´good´ and "distinctions" as ´not good´ is captured by Benner et al who describe the nurse´s "feelings about her ´succesful´ performance" as "mixed".

CHAPTER EIGHT

AUTOMATIC ACTIONS

Introduction

I have stated at the end of the previous chapter that Benner et al interpret the nurse´s feelings about a "succesful" resuscitation of the baby´s "heart rate" as "mixed". Benner et al specify their interpretation of the nurse´s feelings as "mixed". They write: "She is troubled by the infant´s suffering" (Benner et al, 1996:81). According to Benner et al, the nurse is "troubled", because the baby is suffering after his "heart rate" has been succesfully recovered.

The problem of the nurse being "troubled" about the baby´s suffering after the resuscitation, as Benner et al see it, is that she "has little sense of the social power or means to deal directly with this concern" (1996:81-82). The "means" this nurse is lacking in order to "directly" attend to her concern (being "troubled") about the baby´s suffering, Benner et al describe as follows: "She has *not yet developed* the experiental wisdom and *ability to integrate* ethical and clinical concerns" (1996:82; emphasis mine).

Benner et al are suggesting here the possibility that the nurse develops "experiental wisdom", that is, gaining "wisdom" through seeing many situations of patients in everyday work, in other words, practical knowledge, and the *ability to integrate* "ethical and clinical" concerns. That is, the nurse is seen to acquire practical knowledge which enables her to integrate her "practical" concern: the resuscitation of the baby, and her "ethical" concern: the baby´s suffering after that procedure. How is the nurse to achieve this integration of her "practical" concern (the resuscitation of the baby) and her "ethical" concern (the baby´s suffering after the performance)?

Integrating *versus* Effecting

According to Benner et al, the nurse achieves the integration of her "practical" concern and her "ethical" concern, I will show, by preventing the resuscitation as the 'cause' of the baby's suffering. They write about this nurse that she had been:

> ethically and legally accountable to initiate the code since there was no familial and medical agreement to stop treatment. In this social context, *her actions to prevent the code* would have had *to precede* this particular crisis (Benner et al, 1996:82; emphasis mine)

Benner et al are implying here that the nurse, if she would have already acquired 'enough' practical knowledge (she "has not yet developed"), she could have known the suffering the baby will have to endure after a "succesful" resuscitation. Knowing the suffering involved for the baby after the resuscitation, the nurse could have precluded his suffering by avoiding the 'cause' of it: the resuscitation. For example, by turning to the physician. That is, to obtain a medical order of 'no resuscitation' which suspends the nurse's legal (ethical) obligation to initiate a resuscitation in case a cardiac arrest is recognized by a nurse.

Having prevented the prospect of a "successful" resuscitation of the baby in this way, the nurse would have integrated her "practical" concern and her "ethical" concern (the baby's suffering after the resuscitation).

Benner et al underline the nurse's practical knowledge as the condition of knowing what is involved for the patient after a particular action has been performed and thus of being able to integrate her "practical" and her "ethical" concerns. They contrast this nurse at the competent stage "to the proficient and expert nurses in the study" (Benner et al, 1996:82). Nurses at those stages, Benner et al write, "have a more developed sense of moral agency" (1996:82). Their "sense of moral agency" is to "*foresee*

the ethical implications of clinical interventions" (Benner et al, 1996:82; emphasis mine). The nurse at the proficient and expert stage foresees, in the opinion of Benner et al, "ethical implications", that is, her "ethical" concern (for example, the suffering the patient will have to endure after a particular procedure).

I have discussed in Chapters Six and Seven how the nurse's recognition informed by her knowledge produces, in establishing "commonalities" with the situation of the patient, "distinctions". Here, I argue, that the nurse's action informed by her knowledge (for example, initiating and performing a resuscitation) produces, in establishing "commonalities" with the situation of the patient (for example, in terms of 'we have got a "heart rate back"'), "distinctions", such as, the suffering of the patient after the performance of a particular action. The patient's suffering (the nurse's "ethical" concern) is effected through her "practical" concern: initiating and performing an action in order to achieve "commonalities" with the situation of the patient.

In speaking of "ethical *implications* of clinical interventions" (emphasis mine), Benner et al are implying, I suggest, that the nurse who initiated the resuscitation ("clinical interventions") of the baby in the above example *effects* "ethical implications", that is, "distinctions", that is, her "ethical" concern (such as the suffering of the patient after the performance).

In contrast to Benner et al's notion that the nurse will develop 'enough' practical knowledge on the basis of which she *foresees* "ethical" concerns ("distinctions", "ethical implications") the performance of a particular action will bring for the patient; that is, to be able to *integrate* those "ethical" concerns (the patient's suffering) by stopping the action and thus precluding the 'cause' of her "ethical" concerns, the latter are, I suggest, *effected* through her "practical" concerns, for example, initiating and performing a particular action.

The Patient's Recognition

In Chapter Two I have noted that Orlando's idea of "exploration" in terms of an exchange of recognitions between nurse and patient implies that the patient's recognition of his situation is brought about through the nurse's recognition of it. Or, it can be said that the nurse's recognition, in setting up "commonalities" with the situation of the patient, produces "distinctions" from the patient's perspective.

The nurse in the above example who states: "I was hoping he wouldn't" survive, produces the baby's recognition in relation to her recognition (hope). The nurse who recognizes the patient in terms of "I was hoping he wouldn't survive", establishes "commonalities" with the situation of the patient ('hoping that he is not surviving') and effects, at the same time, "distinctions", that is, the patient's recognition in relation to her recognition (hope).

It has been discussed in Chapter Two that, for Orlando, an "exploration", that is, an exchange of recognitions between nurse and patient, is also the condition of accomplishing a sort of correspondence about the situation of the patient. An exchange of recognitions between nurse and patient accomplishes, I suggest, in the light of the discussion in the previous section, a correspondence in the sense of *integrating* the nurse's perspective of the situation and the patient's perspective of it.

The accomplishment of a correspondence between nurse and patient about the situation is, in the opinion of Orlando, the precondition of deciding "deliberatively" about the action to be taken in response to the patient's situation. This deliberating (exchanging of recognitions) between nurse and patient continues, for Orlando, during and after the action.

It may seem rather ridiculous to entertain the idea of the nurse exchanging her recognition ('that he is not surviving') with the baby so that the baby could

articulate his recognition in relation to it in order to deliberate about the action to be followed. But the patient who is *not yet* able to articulate (for example, a baby) or who is *not any more* able to articulate (for example, a patient who has stopped breathing and whose heart function arrested) the recognition of his situation which the nurse´s recognition produces in the first place, is particularly vulnerable.

That is, that the nurse´s certainty about her recognition of the patient´s situation to correspond with the patient´s situation, excludes the patient´s recognition in relation to it *from* her recognition and is, in this way, creating a social distance between herself and the patient.

This social distancing between nurse and patient is increased, when the nurse acts, following Orlando, "automatic". I have argued in Chapter Two that Orlando´s idea of an automatic action can be considered as the enactment of the claim about a correspondence between person and object as raised by cognitive theories of knowledge. The nurse´s certainty that her recognition corresponds with the situation of the patient, hinders her to exchange recognitions with the patient about his situation. It prevents the accomplishment of a correspondence between nurse and patient about the situation of the patient as the precondition of deciding the action to be followed "deliberatively".

In this chapter, I will discuss how Benner et al´s notion of an "intuitive" link between the nurse´s recognition of the patient´s situation and action in response to it at the expert stage is an automatic action. I, then, illustrate how the nurse´s automatic action obliterates the very moment when the nurse could foresee "ethical implications" her action could bring for the patient; or, when the nurse could initiate an exchange of recognitions with the patient.

Second, I discuss how the nurse´s automatic actions enhance the exclusion of the patient´s recognition with

regard to it from her recognition, when they are carried out under conditions of "physical closeness" and "co-operation" (Bauman, 1989) with other actors.

Automatic Actions

Benner et al state that the performance of nurses at the proficient stage is characterized "by an increased capacity for recognizing whole patterns and a budding sense of salience where relevant aspects of the situation simply stand out *without recourse to calculative reasoning* (1996:142; emphasis mine). Since Benner et al connect "calculative reasoning" with theoretical knowledge, they are implying that the nurse´s recognition ("skills of seeing") informed by her practical knowledge is increasingly corresponding with the situation of the patient (when "relevant aspects simply stand out").

Yet the distinction in the advance between the stage of proficiency and expertise is, as Benner et al see it, that the nurse´s recognition at the proficient stage is "not yet linked" to the nurse´s action; at the proficient stage the nurse "still has to think about what to do" (Benner et al, 1996:142). Between the nurse´s recognition of the patient´s situation and her decision about the action to be followed there is still a moment to reflect; that is, to consider the "ethical implications" ("distinctions") her action will bring for the patient from her perspective. Importantly, there would still be a moment to initiate, following Orlando, an exchange of recognitions between herself and the patient in order to decide upon an action "deliberatively".

The hallmark of the nurse at the expert stage is, according to Benner et al, when the "links" between the nurse´s recognition and her action become increasingly "intuitive". Significantly, those links are seen to shift the "focus" of the expert nurse from the "problem" of the patient recognized to the action.

In stressing the "intuitive" links between the nurse´s recognition of the "problem" of the patient and decision

to act which involves shifting the nurse's focus from "problem" to action, Benner et al, I think, assume that the correspondence ("commonalities") between the nurse's recognition and the "problem" of the patient is "strong" enough to 'cover' the actions taken and, because of such an assumption, the nurse is seen to be able to focus her attention on the action rather than the "problem". They write: "The links between patient condition and action are sufficiently strong that the focus shifts to actions taken rather than the problems recognized" (Benner et al, 1996:142). In short, Benner et al assert a correspondence between the nurse's recognition and the situation of the patient and a correspondence between the action of the nurse and the situation of the patient.

Since Benner et al assert a correspondence between the nurse at the expert stage and the situation of the patient that 'covers' the action decided upon, their notion of an "intuitive" link describes an automatic action in that it obliterates the very moment to think about possible "ethical implications" her actions may have for the patient from her perspective; or to exchange recognitions with the patient in order to accomplish a correspondence between nurse and patient about his situation before reaching a decision concerning the action to be followed.

Benner et al illustrate such automatic action with an account by a nurse at the expert stage I have referred to earlier in Chapter Seven. I restate the excerpt from the nurse's account about a patient who had been haemorrhaging and stopped breathing (Benner et al, 1996).

> I looked at his heart rate and I said: 'O.K. he is bradying down. Someone want to give me some atropine?' I just started calling out the drugs that I needed to get for this guy, so we started to push drugs in. In the meantime, I said, 'can we have some more blood?' I was just barking out this stuff (the things that were needed and had to be done). I can't even tell you the sequence. I was saying, 'We need this.' I needed to anticipate what was going to happen and I could do this

> because I had been through this a week before with this guy and knew what we had done (and what had worked). The anesthesiologist came in and did a good intubation. He asks: 'what kind of (IV) lines do we have?' I said, 'We have a triple lumen and we have blood. All (IV) ports are taken. We need another kind of line. He's got no veins left. 'He goes, 'O.K., fine, give me a cut-down tray ... (quoted in Benner et al, 1996:142-143).

The nurse establishes a correspondence between her practical knowledge and the situation of the patient in terms of "bradying down" and makes an automatic request if someone wants "to give me some atropine?". The nurse's request leads to a sequence of actions which involve at least the application of intravenous drugs, for example, atropine, the intubation of the patient to take over/assist his or her breathing function, while a surgical opening of one of the patient's veins was being prepared for as indicated by the request of the anesthesiologist "give me a cut down tray".

The nurse's automatic action of asking for "atropine" excludes the very moment to think, from her perspective, of "ethical implications" ("distinctions") of her action for the patient, let alone of "ethical implications" of a sequence of actions as initiated by her 'original' action of requesting "atropine".

Considering that the nurse's recognition produces, in establishing a correspondence ("commonalities") with the situation of the patient ("bradying down"), also the recognition ("distinctions") of the patient with regard to her recognition, then the nurse's automatic action of asking for "atropine", obliterates the moment for an exchange of recognitions between nurse and patient in order to accomplish a kind of correspondence between nurse and patient about his or her situation as the precondition of deciding the action to be followed "deliberatively".

This exclusion of the patient's recognition ("distinctions") of his situation through the nurse's

recognition of his situation and subsequent actions decided upon automatically by the nurse is enhanced when the performance of those actions involve the "physical closeness" and "co-operation" of nurses and physicians.

Physical Closeness and Co-operation

Bauman (1989), following Milgram, points out that physical closeness and continuous co-operation of actors, even if only over a relatively short time, tend to result in a "group feeling". A feeling of togetherness is produced through joint actions which are complementary in achieving a shared goal (Bauman, 1989:156). At the same time, and this is the point of Bauman, such feeling of togetherness supports the exclusion of the "victim" from the group.

The exclusion of the patient´s recognition as produced through the recognition and automatic action of nurses and physicians from their recognition through their co-operation with one another complete with a sense of togetherness can be highlighted with the following account of a "critical transport" nurse about the resuscitation of two babies as quoted in *Expertise in Nursing Practice*:

> Nurse 1: The residents don´t do transports very often. They are not used to doing as much as the nurse is doing, and the nurses work better together and get the baby ´spiffed up´ faster (resuscitated and stable) because we are just used to doing it, and you just do whatever needs to be done. I was working on one new baby by myself and I got a line in, and then he was working on the other baby and put the line in. And he decided to let the referring physician intubate the other baby, and I was going to intubate my kid and take my time to intubate because my kid was a little more stable, so I had a little extra time to get things ready. And the referring physician was just watching like a hawk. He was amazed, like ´Whoa, the pressure´s on.´ He probably hadn´t done it in ages himself. And so it was kind of fun. We would say, ´My pressure´s this, what´s yours?´ They go, ´Oh well, we haven´t done any of those.´ It´s like: ´we haven´t got the blood pressure.´ It´s fun,

> laughing back and forth about: ´Oh, you do it.´
>
> Nurse 2: Everybody has a specialized role, and you just kind of go back and forth and there´s camaraderie. It´s kind of a nice thing (quoted in Benner et al, 1996:121-122).

The first nurse begins her account by drawing a professional distinction between nurses and physicians. According to her, nurses are usually ´better´ in resuscitating patients (do more; "work better together") than physicians (residents). Her account of a particular experience, however, shows how such professional distinction breaks down when the physician who, in resuscitating ´his´ baby, appears to be learning from the nurse´s way of resuscitating ´her´ baby, while the nurse, who seems to be rather certain about the situation of ´her´ baby and her skill of resuscitating it, responds by prodding the physician in an easy going, colleagial manner to be as fast as she is in getting the blood pressure reading of ´his´ baby.

In contrast to the exchange of recognitions going on between nurse and physician in order to accomplish a correspondence between their actions, the recognitions ("distinctions") of the two babies as effected through those actions, are excluded from the recognition of the professionals. How the two babies fare during that procedure is outside the technical achievement of the professionals´ shared goal: establishing a correspondence ("commonalities") between their action and the situation of the patient, and outside their enjoyment of a feeling of togetherness as cultivated through actions which are complementary in reaching a correspondence with the situation of the patient from *their* perspective.
The second nurse captures the complementarity of actions between nurse and physician as "you just kind of go back and forth" and the sense of togetherness as "camaraderie", a kind of "nice thing".]

CHAPTER NINE

CARING PRACTICES

Introduction

In the chapter where Dreyfus and Dreyfus contribute to *Expertise in Nursing Practice,* they present not only their concept of skill acquisition which I have discussed earlier. In their particular chapter, Dreyfus and Dreyfus also note, following Benner and Wrubel (1989), a division of the patient into disease and illness. They write that: "to Benner and Wrubel *disease* is an organic dysfunction, of which modern medicine has a theory, whereas *illness* is the experience of the breakdown of one´s body and thus of one´s everyday world" (Dreyfus and Dreyfus, 1996:45; emphasis in the original).

Concerning the nurse´s recognition of the patient´s disease and illness, Dreyfus and Dreyfus take the point once more from Benner and Wrubel. According to them: "Nurses are in the unique position of being able to understand *both* the disease experience and the meaning that the patient brings to that experience (Benner & Wrubel, 1989, pp.8-9)" (quoted by Dreyfus and Dreyfus in Benner et al, 1996:45; emphasis mine).

In relation with the division of the patient into disease and illness by Benner and Wrubel (1989) and their claim that the nurse is able to recognize "both", the "disease experience" and "the meaning that the patient brings to that experience", Dreyfus and Dreyfus indicate two descriptions of the nurse´s recognition. These apparently different descriptions of the nurse´s recognition, I will argue, stand for two different interpretations of the nurse´s recognition.

Two Interpretations

Dreyfus and Dreyfus (1996) hint at one description of the nurse's recognition in connection with Heidegger. Following him, Dreyfus and Dreyfus state that "man's way of being is care" and that such way of being "must be understood, preserved, and enhanced by nursing as a caring profession (1996:46). Achieving such caring of the patient's way of being as care, nurses do not seem to require, for Dreyfus and Dreyfus, any knowledge. They further point out that since the human way of being is care, "there can be no abstract, analytical theory of it" (Dreyfus and Dreyfus, 1996:46).

Rather, the nurse's caring of the patient's way of being as care is defined to be a way of "understanding" that is a "higher kind of knowledge" through "entering" the patient's perspective of life by helping: "The best we can come up with is that *caring,* as a way of helping people by entering their world, is a *higher kind of knowledge* which we can call *understanding*" (Dreyfus and Dreyfus, 1996:46; emphasis mine).

Drawing on Heidegger for their definition of caring as "understanding" the patient's perspective of life and such "understanding" to be a "higher kind of knowledge", Dreyfus and Dreyfus choose a theorist who does not presuppose a cognitive principle for his interpretation of recognition (see also Chapters Four and Five). I take Dreyfus and Dreyfus to allude to Heidegger's non-cognitive theory of knowledge when they state that "there can be no abstract, analytical theory" of Heidegger's human way of being as care (1996:46).

Dreyfus and Dreyfus indicate the second description of the nurse's recognition in the following claim: "The nurse, however, is not only involved in the activity of beginning to bear the science and technology of medicine on a specific body with a specific disease, but also caring" (1996:47). Dreyfus and Dreyfus are saying that besides "caring", the nurse is involved in recognizing the "body"

of the patient based on theoretical knowledge ("science and technology").

Defining caring as "understanding" the patient´s perspective of life to be a "higher kind of knowledge" on Heidegger´s non-cognitive theory and differentiating it from the nurse´s recognition of the "body" of the patient based on her theoretical knowledge ("science and technology"), Dreyfus and Dreyfus implicitly link, I propose, theoretical knowledge with cognitive theories of knowledge.

Having argued that Dreyfus and Dreyfus (1996) tie theoretical knowledge with cognitive theories of knowledge and caring as an "understanding" of the patient´s perspective of life as a "higher kind of knowledge" with Heidegger´s non-cognitive theory is to say that the two descriptions of the nurse´s recognition I have shown Dreyfus and Dreyfus to indicate, stand for two different interpretations of the nurse´s recognition.

In this chapter, I show, first, how Benner et al draw on Dreyfus and Dreyfus (1996) and describe two recognitions of the nurse after her "qualitative" leap to the stages of proficiency and expertise in relation with two aspects of the patient: his clinical situation and his concerns. I illustrate, second, the apparent plausibility of two different descriptions of the nurse´s recognition in connection with two aspects of the patient.

Third, I elucidate how Benner et al offer *one* cognitive interpretation of the nurse´s recognition at the stages of proficiency and expertise in that they add the notion of caring to the condition which explains the nurse´s recognition at those stages. I discuss, fourth, how Benner et al divide, in analogy with Benner and Wrubel (1989), the patient into clinical situation and concerns and how, from a non-cognitive interpretation of recognition, the concerns of the patient are effected through the nurse´s recognition of the clinical situation of the patient.

Two Descriptions

Benner et al who are specifically pointing out that they draw on the chapter of Dreyfus and Dreyfus in *Expertise in Nursing Practice* write:

> We have *theoretically* made a distinction between medical and nursing theory related to science and existential caring skills (see Chapter 2) (1996:160; emphasis mine).

Stating that they distinguish "theoretically" between theoretical knowledge ("medical and nursing theory related to science") and "existential caring skills", Benner et al leave it to the reader to clarify the connection between theoretical knowledge and "existential caring skills" with their description of recognition after her "qualitative leap" to proficiency: "skills of seeing" informed by her practical knowledge and "caring practices".

The description of apparently two distinct recognitions of the nurse is indicated when Benner et al claim, for example, that the nurse´s practice at the proficient stage is "now" guided by recognizing the current "clinical" situation of the patient based on her recognitions of "similarities and differences" of "past clinical situations", that is, her practical knowledge, and by recognizing "trends and meanings" in the situation of the patient: "Actions are now much more structured by the *perceptual grasp* of similarities and differences of the current and past clinical situations, *and* with *perceived* trends and meanings in the patient´s situation" (Benner et al, 1996:115; emphasis mine).

The nurse´s recognition of "trends and meanings" in the situation of the patient as distinct from the nurse´s recognition of "similarities and differences" in the clinical situation based on her practical knowledge seems to be, for Benner et al, the sort of "caring practices" which help the nurse to notice what is important in the situation of the patient.

They describe the nurse´s recognition as "caring practices" more specifically when they write: "The nurse proficient in caring practices connects with a particular patient and his or her concerns" (Benner et al, 1996:116). The nurse who connects with the concerns of the patient through her "caring practices" is able to recognize what is important in the situation of the patient: "It is this connection that enables the nurse to understand and respond to what is salient in the situation" (Benner et al, 1996:116).

The nurse´s recognition of what is important in the situation of the patient on the basis of her recognition of the patient´s concerns by way of connection through her "caring practices" is brought out more clearly in relation with a particular account of a nurse, considered to be at the proficient stage. Benner et al conclude about this nurse that: "In fact, it is the nurse´s connection and concern for the child that enables her to judge that the treatment has become both excessive and futile" (1996:133). They are saying that the nurse recognizes through her "connection and concern for the child" the concerns of the child and that this recognition of the child´s concerns "enables her to judge that the treatment has become both excessive and futile". In other words, the nurse has read the thoughts of the child; she established a correspondence between her "caring practices" and the concerns of the child as related to his treatment and, therefore, she is able to pass a judgement about the treatment as having become "excessive and futile".

On account of these examples, I suggest that Benner et al describe two recognitions of the nurse after her "qualitative leap" to proficiency, whereby each recognition is related with a particular aspect of the patient: "skills of seeing" informed by practical knowledge for recognizing the clinical situation of the patient and "caring practices" for recognizing the concerns of the patient, while the nurse´s recognition of the patient´s concerns is seen to enable the nurse to pass a judgement about what is important in the situation of the patient.

Two Descriptions and Aspects Illustrated

The description of two recognitions of the nurse in relation with two distinct aspects of the patient is mirrored somewhat by an advanced beginner nurse who differentiates in her account between her "organizational skills" as well as her practices of "more technical things" related to the "bodies" of the patient *and* her "psychosocial skills" related to the human being of the patient (in Benner et al, 1996: 264).

I want to illustrate with the first part of her account how Benner et al´s two descriptions of the nurse´s recognition for two aspects of the patient appear to be plausible. This is the beginning of her report:

> My organizational skills are really bad. I´m playing catch-up. The psychosocial gets put in the backdrop. The more technical things that would take a more experienced nurse less time will take me half an hour to do, because I´m more conscious of everything that could happen. I am always making sure that what I am doing is the right way .. The first month practicing alone, I hardly ever used psychosocial skills, just the basic questions of: How are you doing? Are you in pain? Do you know where you are?... I am getting better with talking to the patient and being a little more sociable, because ... we forget that they´re human, and we just treat them like bodies (quoted in Benner et al, 1996:264).

This nurse notices that her practices related to matters of organization ("organizational skills") are "really bad" ("playing catch-up"). Yet she seems to be rather conscientious about establishing a correspondence between her knowledge of "everything that could happen" and her practices (the "more technical things"); or between her ideas about the "right way" and her practices ("what I am doing").

She appears to be saying "because" she is using so much time for establishing a correspondence between her knowledge and particular practices, she hardly engages in the practice of talking with patients ("psychosocial skills" get "put in the backdrop"). During her "first month of practicing alone" she only asked patients "basic questions", for example, "How are you doing? Are you in pain?"

Not talking to patients is, in the opinion of this nurse, "just" treating, that is, recognizing patients only like "bodies". Recognizing the patient as a body only is, for her, not treating the patient, that is, not recognizing the patient as a human being ("we forget that they´re human").

Her understanding of recognizing (treating) the patient as a human being requires, then, the achievement of both: her recognition of the body of the patient including particular practices and her recognition of the human being of the patient through the practice of talking to the patient.

She seems to be thinking that such recognition of the patient as a human being is possible. Once she is going to take "less time", that is, like "a more experienced nurse", for her recognition of the body of the patient and practices related with it, she will also recognize the human being of the patient, that is, be able to talk to the patient. She points out that: "I am getting better with talking to the patient and being a little more sociable".

I return now to the distinction Benner et al make between two recognitions of the nurse: her "skills of seeing" and practical knowledge and her "caring practices" and discuss how the notion of caring gets added to the condition which explains the nurse´s recognition after her "qualitative leap" to proficiency.

One Interpretation of the Nurse's Recognition

Benner et al indicate quite clearly, how the nurse's recognition in terms of her "caring practices" is, like her "skills of seeing" and practical knowledge, from the competent stage onwards, developed on the basis of her emotions. They write:

> the *role of emotions* in developing perceptual acuity are related to involvement in the *clinical situation* (problem engagement) and in caregiving involvement with the *patient as person* (Benner et al, 1996:90; emphasis mine).

The nurse's recognition, developed as "perceptual acuity", that is, her "skills of seeing", on the basis of her emotions which are the condition of developing the nurse's practical knowledge (see Chapter Seven), recognizes ("involvement") the clinical situation of the patient *and* the "patient as a person", that is, the concerns of the patient.

Benner et al would want to assert, I suggest, that the nurse's emotions as the condition of developing the nurse's "skills of seeing" and practical knowledge develops also her "caring practices" (or "caregiving").

On the view that theories of knowledge are interpretations rather than descriptions, I argue, that Benner et al only add the notion of caring to the condition which explains the nurse's recognition after her "qualitative leap" to proficiency: the nurse's *development* of "skills of seeing" and practical knowledge on the basis of the nurse's emotions. The implication is that the assertion about a correspondence between the nurse's recognition and the situation of the patient at the proficient and expert stage is now based on a cognitive principle which consists of: the nurse's development of "skills of seeing" and practical knowledge on the basis of the nurse's emotions *and caring*.

If one accepts that Benner et al's descriptions of the nurse's recognition as "skills of seeing" informed by practical knowledge and "caring practices" after her "qualitative leap" to proficiency is *one* interpretation of the nurse's recognition at the stages of proficiency and expertise, then it is reasonable to say that Benner et al divide the patient, in analogy with the division Benner and Wrubel (1989) draw between disease and illness, into clinical situation of the patient and concerns of the patient.

In dividing the patient into clinical situation and concerns of the patient, Benner et al add the concerns of the patient to the nurse's recognition of the patient. Benner et al are repeating, in this way, Abdellah's and Roy's gesture of adding the "patient as a person" to the 'body' of the patient (Chapter Three).

Concerns of the Patient as an Effect

I have discussed in Chapter Eight how the nurse's recognition of the patient's situation and her action in response to it produce, in achieving a correspondence ("commonalities") with the situation of the patient, the patient's recognition ("distinctions") in relation to it; that is, the patient's perspective of the nurse's recognition of his situation and her action in response to it.

So when Benner and Wrubel claim that the nurse is able to recognize both: the "disease experience" and illness as "the meaning that the patient brings to that experience" (1989:45), I suggest, that the "meaning" the patient "brings" to his "disease" is *brought* to the patient through the diagnosis of his particular disease. The physician who establishes on the basis of his knowledge "commonalities" with the situation of the patient, recognizes (diagnoses) a particular disease and effects, at the same time, the recognition the patient has of his *disease*. The patient's recognition of his disease are the "distinctions" brought to him through the physician's recognition of his disease.

Similarly, the nurse who establishes a correspondence ("commonalities") with the clinical situation of the patient, effects the patient´s recognition of it; the patient´s recognition of his clinical situation in relation to the nurse´s recognition of his clinical situation *are* the patient´s concerns. The concerns of the patient are the "distinctions" the nurse´s recognition of his clinical situation produces from his perspective.

How the nurse´s recognition of the patient´s situation and her action in response to it produces concerns ("distinctions") from the patient´s perspective, I want to underline with the second part of the nurse´s account which I have employed above.

This particular advanced beginner nurse continues her report and describes how she is treating a patient who is bleeding (according to Benner et al, a "gastrointestinal bleed") by "lavaging", that is, washing the patient´s stomach (and intestine) through a special tube with "iced normal saline". The nurse says:

> *I started lavaging with iced normal saline, and at the same time, I was asking my patient: ´Are you O.K.? Are you comfortable?´...* I didn´t forget about her, in all my anxiety, that she was bleeding. She wasn´t bleeding as profusely as my other patient was, and this bleeding occurred in this middle of the shift rather than at the end ... But what was good about this patient is that I didn´t forget that she was a patient, and I was talking to her, and it made me feel good because I was so scared (quoted in Benner et al, 1996:264; emphasis mine).

The nurse establishes a correspondence with the clinical situation of the patient in terms of "bleeding" which "occurred in this middle of the shift"; and she attempts to achieve a particular correspondence between her activity of washing the patient´s stomach (and intestine) with "iced normal saline" and the situation of the patient: that the "bleeding" stops.

Yet this nurse obviously tries to recognize both: the clinical situation of the patient ("bleeding"), her action in response to it ('washing the patient's stomach'), *and* the concerns of the patient she effects with her action. She "is asking" her patient "at the same time"; she says: "Are you O.K.? Are you comfortable?" The nurse is aware that her action informed by her knowledge produces the patient's concerns with regard to what she is doing. She demonstrates, I suggest, how her action, in attempting to achieve a particular correspondence with the clinical situation of the patient brings, at the same time, concerns for the patient.

Asking the patient about her concerns (for example, "Are you O.K.?"), this nurse, I propose, comes close to enacting Orlando's idea of an action carried out "deliberatively". She apparently tries to initiate an exchange of recognitions with the patient in order to accomplish a kind of correspondence with the woman about the action in process and thus about the patient's situation.

However, the nurse does not tell the answer of the patient. This nurse illustrates, I argue, on the other hand, that talking to the patient in the way she pointed out in the first part of her account: "being a little more sociable, because .. we forget that they are humans, and we just treat them like bodies", is considered, by this nurse, as treating the patient as a human being; that is, having recognized the patient's concerns from his or her perspective.

The point I wish to make is that 'talking' about the concerns of the patient is assumed to correspond with the concerns of the patient talked about. She says: "I didn't forget about her, in all my anxiety, that she was bleeding". She stresses again: "I didn't forget that she was a patient, and I was talking to her". I am suggesting here that the nurse thinks that her idea of treating the "patient" corresponds with what the woman considers to be treated as a "patient". The nurse seems to equate that

'talking' which did her a lot of good ("and it made me feel good because I was so scared") had the same impact on the patient.

The purpose of asking the patient is, following Orlando, to initiate an *exchange* of recognitions between nurse and patient in order to *accomplish* a correspondence about the situation of the patient. Such exchange of recognitions between nurse and patient, I want to illustrate with an account by another advanced beginner nurse.

Correspondence Accomplished

Benner et al present in the Chapters (1, 3-6) pertaining to their study about an advance in the nurse's recognition in *Expertise in Nursing Practice* about 120 accounts or excerpts of accounts from nurses working in critical care nursing. Among these accounts are a few examples in which the nurse refers *en passant* to what the patient *said* in relation to the nurse's recognition of his situation. This particular example, however, is special. It is the only one in which the nurse actually reports an exchange of recognitions about the situation of the patient between herself and the patient (see also Chapter Twelve).

The patient has passed an operation (Benner et al, 1996) and finds himself with various 'tubes going in and out' of his body. The patient asks several questions about these tubes which the nurse tries to answer. This exchange of question and answer between nurse and patient reveals how the recognition of the situation of the patient of either one constitutes the recognition of the other as "distinctions" in relation to their own.

The patient is, for example, intubated ("E-T tube") through his mouth. The nurse tells him that this tube is "new" and that his "body naturally wants to cough it out". For the patient this particular tube means a "sore" throat and that he feels "like I'm choking". What is for the nurse a chest tube, is for the patient not being able to understand "why he had this low pain when he coughed". From the nurse's perspective the patient gets "plenty of

fluid" through his intravenous line. The patient, however, is worried about being "dehydrated". This is her account:

> So I went in and we (the patient and I) spent the first hour and a half - I was lucky to get his blood pressure taken and the rest of his vital signs because he was writing me so many notes and I had to hold the piece of paper while he wrote. But it ended up, all of his question were totally legitimate. Like, 'Why is my throat sore? I feel like I'm choking.' And I said 'No, the tube's new and your body naturally wants to cough it out. And it will get more numb, probably about the time they decide to take it out'. (Laughs) And that helped. And I untied his hands and I had him explore all his tubes. He also had a chest tube and he couldn't understand why he had this low pain when he coughed; why it hurt down there. So I had him feel the chest tube and I showed him where it went. Then I had him feel his nose, because he had a scratch on his nose. It was the tape, so I had him feel his NG tube and then the E-T tube in his mouth and so he got to feel everything on his hand. ... But he still was kind of panicky and asked 'Aren't I really dehydrated?' So I showed him his IV line and took it down and said 'Look, you get bag after bag of this so you're getting plenty of fluid.' And he calmed down. ... And he wrote me a note that everything was ok and that it really helped, my telling him I would be back and look after everything. And he was really calm the rest of the night (quoted in Benner et al, 1996:62-63).

This example shows how the recognitions of the patient about his situation are brought about by being treated in particular ways after an operation. The concerns ("distinctions") the postoperative treatment brings for the patient are made known to the nurse by the patient. In this case, the patient appears to have taken the initiative by asking questions which produce the answers of the nurse, that is, her recognitions of the situation, to be "distinctions" of his own recognitions and vice versa. Yet the talk that ensues between the two helps to accomplish a kind of correspondence about the situation of

the patient. The patient "wrote" the nurse a note telling her "that everything was ok".

CHAPTER TEN

"PATIENT AS A PERSON"

Introduction

The account of a nurse quoted below, Benner et al classify as a "paradigm case". It illustrates for them:

> The way in which a nurse's clinical judgment is shaped by knowing the patient as a person, and the caring practices that allow a person to reveal himself to the nurse (Benner et al, 1996:20)

In order to read their statement about the "paradigm case", it is necessary to recall a discussion in the preceding chapter. I then pointed out that Benner et al describe two recognitions of the nurse after her "qualitative leap" to the proficient and expert stage as "skills of seeing" informed by practical knowledge *and* "caring practices".

Yet contrary to what Benner et al indicate, I have shown that they only add the notion of caring to the cognitive principle upon which they already assert a correspondence between the nurse's recognition at the proficient and expert stage and the situation of the patient.

From this position, it can be said that this "paradigm case" illustrates how the nurse's recognition of the "patient as a person" (which is another way Benner et al describe the concerns of the patient) is taken to correspond with the "patient as a person".

I have also pointed out in the previous chapter that Benner et al add, similar to Abdellah and Roy, the "patient as a person" to the 'body', that is, the clinical situation of the patient. In Chapter Three I have discussed, moreover, how such 'adding on' increases the nurse's resource of producing the patient's recognition

(that is, with regard to his person as well as his clinical situation) and, if she assumes a 'correspondence', of excluding the patient's recognition from her recognition.

So when Benner et al claim that this "paradigm case" illustrates how the nurse's recognition of the "patient as a person" shapes her "clinical judgment" (that is, how the nurse knows what is important in the situation of the patient), I argue that the nurse who accepts such claim excludes the patient's recognition of his person as well as of his clinical situation from her recognition.

Benner et al introduce this particular "paradigm case" by describing the patient as a black man, age 60, whose arms and legs are paralysed ("quadriplegic"), and who has had radical surgery on his neck for cancer in the past which left him "disfigured". At present, he has an "infection" which apparently caused his "respiratory failure". Benner et al point out that the "health care team" made the decision ("agonizing) to connect this patient with a respirator "knowing" that he might be dependent on it as long as he lives ("might be impossible to wean him")(1996:20).

The nurse begins her account of the "paradigm case" by indicating that a decision to treat this particular patient "fully" had been made ("I think we could have made a decision on not treating the patient fully"). The judgement to treat the patient "fully" involved, I assume, the decision about placing the patient on the respirator. If this is so, then, how this decision was reached, is difficult to discern from the nurse's report. On my reading of the account, the nurse substantiates her judgement about the decision to connect the patient with the respirator which she seems to have been in support of ("And I really stood up for him") *after the fact*.

This is the nurse's account:

> Nurse 1: I think we could have made a decision on not treating him fully, based

on what he looked like and what we thought he was. And I really stood up for him. I don´t think some people ever got beyond just looking at him and just saying: ´This man is disfigured and not able to take care of himself, and whatever.´ As far as prioritizing the beds, if we were really strapped for beds, they would think about putting him on general care and taking him off the ventilator. But no one thought it was an easy decision.

Int: It sounded like you had a strong feeling that he wanted to live. How did that come about and do you know when it came about?

Nurse 1: I think he always had it. He was an incredible fighter. I mean I would see him angry or I would see him withdrawn. But even withdrawn, he was actively withdrawn. He wouldn´t look at you. He would follow you, track you in the room and everything but then would look at you ... At one point in time the physicians were asking him: ´You want to die, don´t you?´ They weren´t trying to do him any harm. No one ever didn´t take care of him. He just gravitated towards these excellent physicians. I don´t know.

Int: What do you think was different about the way you saw him versus the way the doctors saw him when they thought that he wanted to die?

Nurse 1: I don´t think they stood with him and looked at him or gave him a Pepsi, or saw him watch the ball game. He really derived a lot of pleasure from living ... I think it was more of a case of their perception of quality of life versus our perceptions of George´s quality of life and as we got to know him more, and what he was like at the skilled nursing facility, (we concluded) that the quality of life for him was really very good ... They didn´t see him as a social director on his unit. He was a spokesperson for the patients, he helped people who had alcohol and drug poblems. He had a girlfriend there who was also wheelchair-bound and they used public tansportation together. They were the Valentine King and Queen. I think the doctors just looked at him and

> saw 'This is as good as it gets, and this is really depressing, and he is really depressed and so why continue? This is torture.' He was really a big baseball fan and wanted to watch the ball games ... to me that is not someone who has given up. (Later in the same interview after describing his active measures to control his day, she comments) Somebody who is that manipulative or that active in planning my day is really not somebody who doesn't want to have to deal with living or doesn't have the strength to go on (quoted in Benner et al, 1996:20-21).

In Benner et al's comment, following the nurse's account, they point out that the communication with the patient was almost "nonexistent". They write: "At one point in the story the nurse tells how hard it was at first to learn to read George's lips, to understand what he was saying" (Benner et al,1996:21). They quote the nurse as saying that the patient "would be saying, 'Ballgame, ballgame, ballgame,' and I would ask: 'You need to have a bowel movement?' Finally I understood 'ballgame'" (Benner et al, 1996:20). Apparently, once the patient had been put on the respirator, the nurse first learns to read the lips of the patient in order to understand, for example, that he said 'ballgame'. This nurse, evidently, made efforts to communicate with the patient.

With this in mind, I wish to exemplify with the above "paradigm case" how the nurse assumes her recognition of the "patient as a person" to correspond with the "patient as the person". The points I want to underline are, first, how the nurse's certainty about such correspondence dissolves the very necessity of talking to the patient about her recognition of him as a person. Second, how the nurse's certainty that her recognition of the "patient as a person" is 'corresponding', excludes the patient's recognition of his person as well as of his clinical situation - which the nurse produced in the first place - from her recognition. That is, Benner et al's assumption that the nurse's recognition of the "patient as a person" helps her to know what is important in the situation of

the patient ("clinical judgement") helps the nurse who adopts this view to create an almost total social distance to the patient.

Finally, I show how the nurse´s assumption that the *nurses´* as opposed to the *physicians´* recognition of the patient´s "quality of life" to correspond with his "quality of life" produces the physicians´ recognition of the patient´s "quality of life" as "distinctions" from the nurse´s perspective - effecting a social distance between nurses and physicians.

The Nurse´s Certainty about the "patient as a person"

Prompted by the interviewer about how and when *her* "strong feelings" that the patient "wanted to live" came about (the implication being that she knew that the patient wanted to be artificially ventilated), the nurse answers as if her ´strong feelings´ arose as a result of recognizing the patient´s ´strong feelings´ about wanting to live. She says: "I think *he* always had it. *He* was an incredible fighter" (emphasis mine).

She describes how she saw the patient "angry" or "actively withdrawn". The latter is for her, not looking at her and tracking her in the room and "then would look at you". She points out that she "stood with him and looked at him or gave him a Pepsi". She "saw" him watching ball games. The nurse concludes: "He really derived a lot of pleasure from living". She appears to be certain that patient George derives from life what she thinks he is getting from it: pleasure.

The nurse makes it rather clear that her ideas about patient George wanting to live with the respirator guide her recognition about the patient. Somebody who is a baseball fan and wants to watch those games is to her ("to me") not someone "who has given up". Or, somebody who is "manipulative" or actively "planning" her day is, for this nurse, somebody who wants to "deal with living" or has the "strength to go on".

The nurse´s certainty that patient George "always" had "strong feelings" to live is underlined by how she reports about the physicians actually "asking him: ´You want to die, don´t you?´". Her rather ambiguous description of "these excellent physicians" towards whom the patient "gravitated" gives her away that asking the patient himself was something she not only seems *not* to have done herself, but of which she seems to disapprove of.

She even ´protects´ the physicians for having posed the questions to the patient: "They weren´t trying to do him any harm. No one ever didn´t take care of him". As if asking the patient is not caring for the patient. Significantly, the nurse does not report the reaction or the answer of the patient when being confronted with the question by the physicians which brought him into a position to make a decision about his life in one way or another.

For this nurse it does not seem necessary that the patient is consulted whether he wants to continue with the respirator or not. She is certain that her recognitions of the patient represent *his* "strong feelings" about wanting to live with that device for the rest of his life. The nurse´s certainty about her recognition of the "patient as a person" to correspond with the "patient as a person" makes the very necessity of exchanging her recognitions with the patient absent from her recognition of the patient.

How the clinical situation of the patient is made absent through the nurse´s recognition of the "patient as a person" *from her perspective* can be highlighted in this example with the fact that the description of the patient´s clinical situation is missing in the account of the nurse. Apart from her statement that: "This man is disfigured and not able to take care of himself, and whatever", she makes no reference to the patient´s respiratory failure, his infection, his being ventilated, his paralysis of his arms and legs ("quadriplegic"), his cancer, or his status after a radical neck surgery (Benner

et al, 1996). The nurse does not describe with a word that she may have observed this patient being in physical discomfort because of the respirator and so on.

But more importantly, the nurse´s recognition of the "patient as a person" which produces, simultaneously, the patient´s recognition with regard to it as well as with regard to his clinical situation makes, if assumed to correspond with the "patient as a person" (that is, for Benner et al, "clinical judgement" or knowing what is important in the situation of the patient) those recognitions also absent from her recognition, effecting an almost total social distance to the patient.

I want to illuminate with this "paradigm case", finally, how the nurse´s recognition of the patient´s "quality of life" produces the physicians´ recognition of the patient´s "quality of life" as "distinctions" from the nurse´s perspective.

Further "distinctions"

When asked by the interviewer what she thinks "was different" between the "way" the physicians recognized the patient "when they thought that he wanted to die", the nurse answers: "I think it was more of a case of *their* perception of George´s quality of life versus *our* perceptions of George´s quality of life" (emphasis mine). The nurse describes how "our" perception, which I take to be her perception and those of her nurse colleagues, of the patient´s "quality of life" were constituted in contrast to the perception of physicians. She says, for example: "I don´t think they stood with him and looked at him or gave him a Pepsi, or saw him watch the ballgame".

The nurse is saying that the recognition of nurses when standing with the patient and looking at him, giving the patient "a Pepsi", or seeing him watching the ballgame, practices the physicians are obviously not engaging in, is a different recognition than that of physicians. She appears to assume that the recognition of nurses is

informed through the "quality of life" the patient displays to them on those occasions and over time. She notes "and as we got to know him *more,* and what he was like ... (we concluded) that the quality of life for him was really very good" (emphasis mine).

This nurse does not seem to think that the recognition of nurses, like that of physicians, is based on knowledge and, therefore, constituting the "quality of life" the patient is recognized to have. Her notion that it works the other way around, the patient´s "quality of life" constituting the nurse´s recognition, and because nurses are standing with the patient and seeing him over time, the recognition of nurses is implied to correspond with the "quality of life" of patient George.

In contrast to the recognition of nurses, she describes the "way" physicians recognize the patient´s "quality of life" as "just" looking: "I think the doctors just looked at him and saw ´This is as good as it gets, and this is really depressing, and he is really depressed and so why continue. This is torture´". Apparently "just" looking does not give the physicians the input about the "quality of life" of the patient nurses obtain from standing with him and looking at him. Indeed, she comes close to saying that in order to recognize the "quality of life" of the patient it is necessary to stand with him and look at him, for example, when he watches the ballgame. She says: "I don´t think some people ever got *beyond* just looking at him and just saying: ´this man is disfigured and not able to take care of himself, and whatever´" (emphasis mine).

Assuming a correspondence between the *nurses´* recognition and the patient´s "quality of life" and appearing to deny such correspondence to exist between the *physicians´* recognition and the patient´s "quality of life", the nurse establishes the physician´s recognition of the patient´s "quality of life" as "distinctions" from the nurse´s perspective - effecting a social distance between nurses and physicians.

CHAPTER ELEVEN

ORLANDO´S ´SOLUTION´ AND BENNER ET AL´S ´SOLUTION´

Introduction

One chapter in *Expertise in Nursing Practice* is written by Rubin. Her intention is to describe "primarily" the practice of a sample of nurses who were identified by their supervisors or head nurses "to be safe, but not superior practitioners" (Rubin, 1996:171). The aim of selecting a group of nurses with the same amount of years of experience as expert nurses (more than five), but considered to be *not* experts, was to capture "variability" of nurses´ practice (Benner et al, 1996:XVII).

How the practice of experienced but *not* expert nurses varies from that of expert nurses is exposed, according to Rubin, in their language. Rubin writes: "expert nurses speak a language of *needs* rather than *wants*" (1996:185; emphasis mine). Rubin exemplifies a "language of needs" with a statement from an account of a nurse, considered to be an expert, about her work with dying patients. The nurse says:

> You sort of assess what that particular family *needs*. And when you come into a room, and if you´re working with them for a long time, it just sort of is happening, what they *need* (quoted in Benner et al, 1996:186; emphasis by Rubin).

This nurse obviously assumes that her assessment (recognition) of the family´s "needs" corresponds with what the family thinks to be their needs. This kind of certainty about her recognition is, for Rubin, evident in the nurse´s "language of needs". The "use" of this language indicates, in her opinion, the "ability" of expert nurses "to *engage* with their patient" (Rubin, 1996:186; emphasis mine).

According to Benner et al, the nurse's recognition is "engaged" after her "qualitative leap" to proficiency and expertise (see Chapter Six). Benner et al assert that the nurse's "engaged" recognition, that is, one informed by the nurse's "skills of seeing" and practical knowledge, corresponds with the situation of the patient.

So when Rubin notes that the expert nurses' "language of needs" is an "indication of their ability to *engage* with their patients" (emphasis mine), then, the "language of needs" implies, for Rubin, I suggest, Benner et al's assertion about the nurse's recognition at the expert stage to correspond with the situation of the patient.

The nurse who assumes, for one reason or another, that her recognition corresponds with the situation of the patient recognized, is seen to express this assumption in a "language of needs". She practices, in Rubin's opinion, Benner et al's assertion that nurses at the expert stage have developed the ability to establish a correspondence with the situation of the patient in everyday work.

Rubin distinguishes the "language of needs" of expert nurses from the "language of wants" of experienced but *not* expert nurses. She writes:

> On those rare occasions when they speak of a patient needing something, they invariably speak either of *asking the patient to tell them* what they need or of the patient's need to control their emotions or behaviour without help from the nurse (Rubin, 1996:186).

But what is wrong with nurses who have been practicing critical care nursing for more than five years asking the patient to tell them their "need"? Asking the patient to tell his "need" indicates, for Rubin, that these nurses "use the language of *wants*" which is "a way of *disengaging* from their patients" (1996:186; emphasis mine).

I have discussed in Chapter Six that Benner et al associate an "objective *disengaged* criterial" (emphasis

mine) recognition with the nurse´s recognition that is not corresponding with the situation of the patient. In particular, they assert that the advanced beginner nurse´s recognition informed by theoretical knowledge is ´not corresponding´, that is, "objective *disengaged* criterial".

The experienced but *not* expert nurse´s way of "*disengaging* from their patients" (emphasis mine) which she shows, according to Rubin, in a "language of wants" (or when the nurse is asking the patient to tell his "need") implies for Rubin, then, Benner et al´s assertion about the nurse´s "objective *disengaged* criterial" recognition as ´not corresponding´.

That is, nurses who do *not* assume that their recognition corresponds with the situation of the patient, show this assumption in a "language of wants". These nurses are not seen to endorse Benner et al´s assertion that the nurse *develops* a ´corresponding´ ("engaged") recognition. These experienced but *not* expert nurses have, as implied by Rubin, *not* progressed from the advanced beginner to the expert stage.

The difference between expert nurse and experienced but *not* expert nurse is, then, according to Rubin, that the former assumes a ´correspondence´ and reveals this assumption in a "language of needs". In contrast to the experienced but *not* expert nurse , who does not assume a ´correspondence´. She expresses this assumption in a "language of wants".

If one accepts that the expert nurse practices Benner et al´s assertion about ´correspondence´ in everyday work, as noted above, then the experienced but *not* expert nurse can be seen, I suggest, to enact Orlando´s idea of "exploration" which implies that the nurse´s recognition is ´not corresponding´; and which considers an exchange of recognitions between nurse and patient to be the condition of accomplishing a kind of correspondence about the situation of the patient and the action to be followed.

On the view that the experienced but *not* expert nurse achieves Orlando´s idea of "exploration" (non-cognitive and minimal cognitive interpretation) and the expert nurse Benner et al´s assertion about a ´corresponding´ recognition (cognitive interpretation) in everyday work, my interest, as stated in the Introduction, is to show how Orlando´s ´solution´ to the uncertainty of the nurse´s recognition differs from Benner et al´s ´solution´ to the uncertainty of the advanced beginner nurse´s recognition.

To this end, I turn to Rubin´s discussion of an example which Rubin qualifies to be a "paradigm case" of the practice of experienced but *not* expert nurses. Rubin is of the opinion that this nurse makes two "very important" assumptions about a particular patient. On the basis of the assumptions the nurse is thought to have made, Rubin discusses the difference between the practice of experienced but *not* expert nurses and expert nurses.

Since Rubin does not present the "paradigm case" ´in one piece´, I will state, first, some parts of the nurse´s account about a particular patient in order to orientate the reader about the situation of this patient. Second, I present *one* assumption this experienced but *not* expert nurse has made, according to Rubin. In connection with Rubin´s discussion of this assumption, I draw out, third, the crucial difference between Orlando´s ´solution´ and Benner´s ´solution´ concerning the uncertainty of the nurse´s recognition.

The Situation of the Patient

This particular nurse was asked by the interviewer to describe "a clinical situation that is vivid to you, that you remember" (1996:172). Following Rubin, the nurse responds in the following way:

> I`ll tell one that I´m sure you´ve heard before about someone who ... was admitted on a Saturday and had a chronic illness and was elderly and had lost her home and was being asked to move into a nursing

> home and she had to give up her pets and so on. And by Sunday, she .. had changed her mind, was ready to die and was dying and there wasn't a lot that could be done to prevent it anyway unless she wanted to be intubated and have a long course and probably die anyway, and opted not to be intubated and to take - what did she take? - some minor Valium or something. I've forgotten what, and stopped breathing, basically. That to me was vivid. (quoted in Benner et al, 1996:172).

The nurse tells about an elderly patient with a "chronic illness" who is admitted on a Saturday, I assume, to a critical care unit. This patient "had lost her home" which appears to imply that the patient had already moved "into a nursing home" and had already given up "her pets and so on" when she was admitted to the hospital.

On the day after her admission, Sunday, this patient is described to have "changed her mind"; that is, the patient is recognized by the nurse as "ready to die and was dying".

In order to get an idea about this "change" in the patient's mind it is helpful to read how the nurse describes the patient's breathing after the "respiratory treatment" had been stopped (at least that is my understanding of the excerpt). The nurse says:

> A lot of difficulty breathing .. She was extremely short of breath; she was cyanotic; she was using her head to breathe and her neck to breathe, and her belly to breathe; and she was contracted such that there wasn't a lot of motion to begin with. So every word was an effort .. It was sort of the respiratory treatment that was supporting her through Saturday. So as soon as she quit and made that decision to stop that, then she started getting really uncomfortable and deteriorating even more quickly (as quoted in Benner et al, 1996:181).

So the events appear to have evolved from the patient being admitted on Saturday, then receiving some sort of

"respiratory treatment" (which was not an artificial respiration in terms of an intubation) until sometime on Sunday, when the patient, according to the nurse, "had changed her mind, was ready to die and was dying". The nurse underlines how close she thought that the patient was to her dying when she says:

> I mean, there wasn't anything, unless, unless, she was intubated .. there was just nothing, no place for her to go. She was going anyway. ..... As soon as she even, if she just got tired and fell asleep on her own, I knew that would be the last time she fell asleep. She just looked terrible (as quoted in Benner et al, 1996:188).

In order to discuss that this account presents the practice of experienced but *not* expert nurses, Rubin analyses two assumptions this nurse makes about the situation of the patient. I present one of these assumptions.

The Nurse's Assumption

For Rubin, one of the assumptions this nurse makes is "that the patient has decided not to struggle with issues of living in her new setting"; the nurse is seen to arrive at this assumption although she "admits" that she has no "direct knowledge of the patient's having made the decision to discontinue the treatments that were keeping her alive" (Rubin, 1996:174). Rubin points out that the nurse says, for example, "I don't know how she came to it" (quoted in the excerpt below); Rubin emphasizes: "She does not even seem to have indirect knowledge, such as reports from others who were present, that this was, in fact, the woman's decision" (1996:174).

Rubin supports the assumption the nurse is seen to have made with the following excerpt of the nurse's account:

> Nurse: She had lived up until that time in her home and was very active in the community, and had a lot of friends and

> support, but over the years that just sort of dwindled. And I was just struck with the rapidity of how quickly she changed her mind, but how at the same time she remained trustworthy, I guess, in her decision.
>
> Int.: But when you say, "changed her mind," she changed her mind from what to what?
>
> Nurse: She changed her mind from struggling with the issues of how to live in her new setting without her furniture, without her pets, without her former support group, uh, to deciding not to live.
>
> Int.: Do you know how she came to go through that transition? Did she verbalize to you at all or did she talk to anybody else about it?
>
> Nurse: No. *I don't know how she came to it*. I'm sure that it was not news to her that she was chronically ill and had to make some decisions. *And I wasn't there*, I don't think I was there when the actual change occurred. I mean, one day she was wanting to struggle, could barely breathe and so on. You know, frequent blood gasses and all the treatments and she was, you know, frustrated that she couldn't rest and the next day she had pretty much decided. *So I guess it happened when I wasn't there*. I don't think I had a lot to do with it. I think she had everything to do with it (quoted in Benner et al, 1996:174; emphasis mine).

Rubin explains her reading of the account that the nurse assumed "that the patient has decided not to struggle with issues of living in her new setting" further when she writes, for example: "this nurse makes no attempt to find out the meaning, for this specific patient, of leaving her home, her support group, her pets, and so on" (1996:173-174).

In connection with this particular assumption the experienced but *not* expert nurse is seen to have made, Rubin discusses the "meaningfull distinctions" this nurse

should have, in Rubin's opinion, noticed. This discussion about "meaningful distinctions" I utilize to show how Orlando's 'solution' concerning the uncertainty of the nurse's recognition differs from Benner's 'solution'.

The Crucial Difference

In drawing out the "meaningful distinctions" which are missing from this experienced but *not* expert nurse's account, Rubin states: "First of all this nurse makes no meaningful distinctions between different patients" (1996:175). Stressing her point that this experienced but *not* expert nurse does not distinguish between "different" patients, Rubin says: "Another way of putting this is that the idea that their patients have *individual, subjective experiences of and understandings* of their situations seems to be completely unavailable to them"(1996:176; emphasis mine). So what is the nurse to do in order to recognize the "individual, subjective" experience and "understandings" this particular patient has of her situation 'leaving her home'?

What Rubin would have wanted this experienced but *not* expert nurse to do is, to have recognized the patient's information in terms of her knowledge which she should have developed during her experience of more than five years of critical care nursing. Rubin writes:

> Presumably, a nurse with this number of years in critical care would have taken care of many elderly patients who had been in situations similar to that of this patient. One would expect that, on the basis of this experience, she would recognize that patients experience this situation in many different ways. Her recognition, for example, that other patients have been able to find their lives worth living despite their having to undergo such a major upheaval, might allow her to see her patient's current despair as one possible response, rather than the only possbile response, to her situation. *This would both allow her to empathize with the patient's perspective and to*

offer alternatives (1996:175; emphasis mine).

The claim of Rubin is that the experienced but *not* expert nurse´s recognition of the patient´s situation ´leaving her home´, if it would have been informed by her practical knowledge (that is, her knowledge of "many elderly" patients in a similar situation to that of this particular patient), it would have allowed her to "empathize" with *and* to offer "alternatives" to this patient.

To put it differently, Rubin implies that the *expert* nurse, because of her practical knowledge of "many elderly" patients, would have recognized the situation of this particular patient and offered her "alternatives". That is, following Benner et al´s cognitive interpretation of the expert nurse´s recognition, the expert nurse can assume that her recognition of the patient´s situation of ´leaving her home´ in terms of her knowledge of "many elderly" patients corresponds (emphathizes) with the situation of this particular patient.

From the view of Orlando´s non-cognitive interpretation of recognition, however, the expert nurse´s recognition of this particular patient in terms of her knowledge of "many elderly" patients is seen to produce, simultaneously, the patient´s recognition in relation to the expert nurse´s recognition; that is, the patient´s recognition as informed by her "individual, subjective" experience and "understandings" (Rubin, 1996) of ´leaving her home´ offers "alternatives" to the expert nurse´s recognition informed by her knowledge of "many elderly" patients.

Yet the *expert* nurse´s certainty about a correspondence of her recognition with the situation of this particular patient dissolves, I propose, the very necessity of an exchange of recognitions with this patient about ´leaving her home´. Instead, it excludes the patient´s "individual, subjective" experience and "understandings" of ´leaving her home´ as "alternatives" to the expert nurse´s knowledge of "many elderly" patients *from* her recognition.

This exclusion of the patient´s "individual, subjective experience" and "understandings" of ´leaving her home´ from the expert nurse´s recognition effects the social distance between the expert nurse and this particular patient.

On the other hand, Orlando´s minimal cognitive interpretation of the nurse´s recognition which suggests an exchange of recognitions between nurse and patient implies that the experienced but *not* expert nurse, offers the patient the opportunity to articulate her "individual, subjective" experience and "understandings" of ´leaving her home´ ("alternatives") in relation to the nurse´s recognition based on her knowledge of "many elderly" patients in order to accomplish a kind of correspondence between nurse and patient about the patient´s situation as the precondition of deciding about the action to be followed "deliberatively". The experienced but *not* expert nurse creates, in this was, the possibility of decreasing a social distance between nurse and patient.

The crucial difference between Orlando´s ´solution´ and Benner et al´s ´solution´ concerning the uncertainty of the nurse´s recognition is, then, that the former suggests while the latter dissolves the necessity of exchanging recognitions between nurse and patient as the possibility of accomplishing a sort of correspondence about the patient´s situation which serves as the basis of deciding further actions.

CHAPTER TWELVE

SUMMARY AND OUTLOOK

Cognitive and Non-cognitive Theories of Knowledge

The claim of this thesis is that the nurse´s recognition is not corresponding with the situation of the patient. This is the case regardless of whether the nurse is informed by her "skills of seeing" and practical knowledge, learned in everyday work, or by her theoretical knowledge, learned in nursing school. This claim accepts the position of non-cognitive theories of knowledge, for example, Derrida´s. In non-cognitive theories, the person´s recognition of objects is uncertain. This position is opposed to cognitive theories which claim that a correspondence between person and object is certain.

My interest was to show how the nurse´s certainty about a correspondence between her recognition as informed by her knowledge and the situation of the patient in everyday work excludes the patient´s recognition from her recognition. The effect is the creation of a social distance between herself and the patient. Another aim was to show how the nurse´s uncertainty about a correspondence allows nurse and patient to exchange their recognitions. Such exchange, understood as the possibility of accomplishing a kind of correspondence, decreases a social distance between the two.

Achieving these aims involved an explication of how Orlando´s (1961) idea of "exploration" as an exchange of recognitions between nurse and patient about the situation of the patient implies a non-cognitive interpretation of the nurse´s recognition (Chapter Two). Orlando´s idea of "exploration", I have argued, constitutes, on the other hand, a minimal cognitive interpretation; it states an exchange of recognitions between nurse and patient as the condition of accomplishing a kind of correspondence about the patient´s situation. Orlando´s notion of the nurse´s

action decided upon "deliberatively" has been considered, furthermore, as the enactment of Orlando´s non-cognitive and minimal cognitive interpretation of recognition; while her notion of "automatic" actions are understood as the enactment of the claim raised by cognitive interpretations of recognition.

In Chapter Three I have elucidated how Johnson´s (1974) idea of reformulating "borrowed" theory into a science *unique* to nursing constitutes conceptions of nursing of individual nursing theorists as cognitive principles upon which the assertion about a correspondence between the nurse´s recognition informed by a particular conception of nursing and the situation of the patient can be made.

I have exemplified how the nurse´s recognition when based on Abdellah´s (1960) conception of nursing of ´the whole patient´ in terms of "biological, physical and social-psychological" nursing problems is not corresponding with ´the whole patient´ or when based on Roy´s (1984) conception of the person as a holistic adaptive system is not corresponding with the person as a holistic adaptive system. That is, I have shown how the nurse´s recognition, for example, of the patient´s "biological, physical" nursing problems effects, *simultaneously*, the patient´s recognition of his "biological, physical" *and* of his "social-psychological" nursing problems.

Moreover, I have pointed out, how Abdellah´s conception of nursing adds the "patient as a person" in terms of "social-psychological" nursing problems to the disease condition of the patient (or "biological, physical" nursing problems), while Roy´s conception adds the person of the patient in terms of a cognator subsystem to the "biological organism" of the person (or a regulator subsystem). Such ´adding on´ of the "patient as a person" is only increasing the nurse´s knowledge as the condition of producing the patient´s recognition of his situation. Importantly, if the nurse assumes her recognition to correspond with the situation of the patient, she excludes the patient´s recognition from her recognition and

creates, in this way, a social distance between herself and the patient.

I have discussed in Chapter Four how Dreyfus and Dreyfus (1996) explain the person's acquisition of intuitive skill in terms of the person's brain processes. This means that Dreyfus and Dreyfus presuppose a physiological principle as the condition of explaining that the nurse's recognition at the proficient and expert stage corresponds with the situation of the patient. Yet I have argued that the brain processes are themselves effects of the person's recognition. If this is so, then a physiological principle as the condition of possibility of explaining the person's skill acquisition is also its condition of impossibility.

I have further argued that a study about the nurse's skill acquisition, following Dreyfus and Dreyfus, would require physiological accounts of the nurse's brain processes. These physiological accounts would be necessary in order to validate the acquisition of an ability the nurse's brain displays at the proficient and expert stage; that is, an ability the nurse's brain did not possess at the advanced beginner stage.

I have elucidated how Benner et al's study of the nurse's skill acquisition, following Dreyfus and Dreyfus, is based on cognitive accounts of the nurse's 'brain processes'. The point is that Benner et al exchange a physiological principle as presupposed by Dreyfus and Dreyfus (1996) with a cognitive principle in order to explain the nurse's skill acquisition.

In Chapter Five I have elucidated how, for Benner et al, cognitive and non-cognitive theories of knowledge are descriptions rather than interpretations of the nurse's recognition. This understanding of Benner et al has the consequence that the claims of theories of knowledge are inverted: a non-cognitive theory describes, for them, the nurse's recognition as 'corresponding'; while a cognitive theory describes the nurse's recognition as 'not corresponding'.

On this analysis, I have argued that Benner et al´s understanding of theories of knowledge to be descriptions instead of interpretations is their *raison d´être* for rejecting the claim of cognitive theories of knowledge with regard to the advanced beginner nurse´s recognition and theoretical knowledge; this rejection is, in turn, the *raison d´être* of their conception about a progression in the nurse´s recognition from the advanced beginner stage to the stage of expertise.

These arguments I have substantiated in Chapter Six. I have discussed how Benner et al´s understanding of a "Cartesian view" (cognitive theories of knowledge) describes the person´s, in particular the advanced beginner nurse´s recognition and theoretical knowledge to be "objective, disengaged, criterial", that is, as not corresponding with the situation of the patient; and I have explicated how Benner et al reject the claim about a correspondence between person and object as put forward by cognitive theories of knowledge with regard to the advanced beginner nurse´s recognition and theoretical knowledge from nursing school in everyday practice.

I have elucidated how Benner et al conceptualize the nurse´s development of "skills of seeing" and practical knowledge as the condition upon which the assertion about a correspondence of the nurse´s recognition at the proficient and expert stage with the situation of the patient can be made; that is, how they re-constitute a cognitive principle and how their assertion about a ´correspondence´ at those stages repeats the claim of cognitive theories of knowledge.

On Benner et al´s understanding of a "Cartesian view", the person establishes "similarities" and "differences" with objects in the world. Further, they demand that the nurse must recognize "commonalities" and "distinctions" with the situation of the patient. Taking these matters together, I have illustrated how Benner et al repeat the claim of a "Cartesian view" (cognitive theories of knowledge) by asserting that the nurse´s recognition of "commonalities"

corresponds with the situation of the patient at the proficient and expert stage.

In contrast to this assertion about a 'correspondence', I have illustrated how the nurse's recognition of "commonalities" with the situation of the patient effects "distinctions", that is, the nurse's practical knowledge. I have emphasized that a non-cognitive theory of knowledge explains how the nurse's practical knowledge ("distinctions") in everyday work comes about. The implication is that a non-cognitive theory of knowledge disintegrates the condition (the nurse's development of "skills of seeing" and practical knowledge) from which Benner et al derive their claim about an advance in the nurse's recognition in terms of stages from advanced beginner to expertise; that is, a progression from an "objective, disengaged, criterial" recognition (not corresponding) to an "engaged" recognition (corresponding).

In Chapter Seven I have pointed out that Benner et al take "our Cartesian legacy" (theories of knowledge with a cognitive principle) to separate the person's emotion from knowledge in a concrete sense and that this separation entails, for them, a distrust in "emotional language".

In connection with Benner et al's rendering of "our Cartesian legacy", I have argued two points: one is that Benner et al consider the advanced beginner nurse's emotions and theoretical knowledge to be separate; the other is that they consider their conception about an advance in the nurse's recognition to describe how the nurse's emotions and practical knowledge *become* mutually constitutive from the competent stage onwards.

I have elucidated how the understanding of Benner et al of "our Cartesian legacy" of separating emotion from knowledge in a concrete sense is not Vetlesen's (1994) in that his theory of moral perception assumes a 'givenness' of the person's mutuality of emotions and knowledge which he conceives in a particular way.

Benner et al's understanding of "our Cartesian legacy" of separating the person's knowledge and emotions involves a distrust in "emotional language". Since Benner et al conceive the advanced beginner nurse's emotions and theoretical knowledge to be separate, Benner et al, I have claimed, distrust the "emotional language" of advanced beginner nurses. This claim I have explicated by revealing how Benner et al refuse to acknowledge the advanced beginner nurse's mutuality of emotions and knowledge as displayed in their language.

I have shown how Benner et al disclose their trust in the "emotional language" of nurses from the competent stage onwards by asserting that the nurse's recognition corresponds with the situation of the patient. This assertion implies, for Benner et al, that the nurse's emotions and practical knowledge have become mutually constitutive.

On the view that theories of knowledge are interpretations rather than descriptions of the nurse's recognition, I have noted that Benner et al add the nurse's emotions to the condition (the nurse's development of "skills of seeing and practical knowledge on the basis of the nurse's emotions) which explains the advance in the nurse's recognition. Benner et al's assertion that the nurse's recognition is "qualitatively" different from the advanced beginner nurse's recognition informed by theoretical knowledge *because* it is based on the nurse's "skills of seeing" and practical knowledge is, therefore, seen to repeat the claim of cognitive theories of knowledge.

I have explicated how Benner et al assert that the nurse's recognition in terms of "commonalities" and "distinctions" corresponds with the situation of the patient; I have explicated further how Benner et al correlate the nurse's recognition of "commonalities" and "distinctions" respectively with notions of good and not good; and I have illustrated how, for Benner et al, the nurse's development of practical knowledge through recognitions of "commonalities" as good and "distinctions" as not good is

the development of the nurse´s ethical knowledge in that sense.

Opposed to these assertions of Benner et al, I have exemplified how the nurse´s recognition in establishing "commonalities" with the situation of the patient effects "distinctions" from her perspective and that, on this view, the correlation of notions of good and not good respectively with the nurse´s recognition of "commonalities" and "distinctions" is rather uncertain.

In Chapter Eight I have discussed how the nurse at the proficient and expert stage is claimed to be able to integrate her "practical" concern (such as, the performance of a particular procedure) and her "ethical" concern (such as, the suffering of the patient after the performance of that procedure) on the basis of her practical knowledge. According to Benner et al, the nurse at the proficient and expert stage achieves this integration of her "practical" and "ethical" concerns by *foreseeing* the "ethical" concern (for example, the patient´s suffering after the operation) in order to prevent the performance of a particular procedure as the ´cause´ of the nurse´s "ethical" concern.

In contrast to Benner et al´s idea that the nurse develops this particular ability of *integrating* "ethical" and "practical" concerns on the basis of her practical knowledge, I have argued that the nurse´s "ethical" concern is effected through the performance of a particular procedure ("practical" concern).

In order to underline how the expert nurse´s certainty that her recognition of the patient´s situation and her action in response to it correspond with the patient´s situation and the action needed by it, I have recalled Orlando´s idea of "exploration" in Chapter Eight. According to Orlando´s idea of "exploration", the nurse´s recognition produces the recognition of the patient in relation to it (non-cognitive interpretation); while the exchange of recognitions between nurse and patient is the condition of accomplishing a kind of correspondence about

the situation of the patient (minimal cognitive interpretation).

This accomplishment of a correspondence is, for Orlando, the precondition of deciding about the action to be followed "deliberatively". I have also reiterated that Orlando's idea of an "automatic" action can be considered as the enactment of the claim about a correspondence as raised by cognitive theories of knowledge and that such an enactment excludes the patient's recognition from the nurse's recognition in that it prevents an exchange of recognitions between nurse and patient effecting a social distance between the two.

On this account, I have argued that Benner et al's notion of an "intuitive" link between the nurse's recognition and action at the expert stage is an automatic action. It obliterates the very moment that the nurse could "foresee" the "ethical implications" of her actions from her perspective; or, that she could initiate an exchange of recognitions with the patient about his situation and the action to be followed.

I have exemplified how the exclusion of the patient's recognition from the expert nurse's recognition is enhanced when the performance of those automatic actions involves the "physical closeness" and "co-operation" (Bauman, 1989) of nurses and physicians.

In Chapter Nine I have shown how two different recognitions of the nurse: care, as "understanding" the patient's perspective of life that is a "higher kind of knowledge", following Heidegger, and the nurse's recognition of the "body" of the patient based on theoretical knowledge, which Dreyfus and Dreyfus (1996) indicate (in relation with the division of the patient into disease and illness by Benner and Wrubel (1989) and their claim that the nurse is able to recognize both) denote two interpretations of recognition as conceptualized by Heidegger's non-cognitive theory of knowledge and by cognitive theories of knowledge.

I have noted that Benner et al (1996), drawing on Dreyfus and Dreyfus (1996), distinguish "theoretically" between theoretical knowledge and "existential caring skills". This distinction, I have shown, turns up in their study as two distinct descriptions of the nurse´s recognition after her "qualitative leap" to proficiency. Benner et al describe each recognition in connection with a particular aspect of the patient: "skills of seeing" and practical knowledge with regard to the clinical situation of the patient and "caring practices" with regard to the concerns of the patient. I have illustrated with an account of a nurse how Benner et al´s description of two recognitions in relation with two different aspects of the patient appears to make sense.

On the view that theories of knowledge are interpretations, I have discussed that Benner et al only add the notion of caring to the condition which explains the nurse´s recognition after her "qualitative leap" to proficiency in the first place. Their assertion about a correspondence between the nurse´s recognition at the proficient and expert stage is derived from a cognitive principle which comprises the nurse´s development of "skills of seeing" and practical knowledge on the basis of the nurse´s emotions *and caring*.

From the position that Benner et al present *one* interpretation of the nurse´s recognition at the stages of proficiency and expertise, I have argued that Benner et al divide the patient, in accordance with the division Benner and Wrubel (1989) draw between disease and illness, into clinical situation of the patient and concerns of the patient. I have pointed out that Benner et al add, through this division, the concerns of the patient to the nurse´s recognition of the clinical situation of the patient. They reiterate, in this way, Abdellah´s and Roy´s ´adding on´ of the "patient as a person" to the ´body´ of the patient.

I have illustrated with an example how the nurse´s recognition of the clinical situation of the patient and her action in relation to it, effect, in establishing "commonalities" with the clinical situation of the

patient, "distinctions"; that is, the patient´s recognition in relation to the nurse´s recognition of the patient´s situation and action in response to it. On this view, I have exemplified how an exchange of recognitions between nurse and patient constitutes the condition of possibility of accomplishing a correspondence between nurse and patient about the situation of the patient.

In relation with a "paradigm case", I have explicated in Chapter Ten how the nurse´s certainty about her recognition of the "patient as a person" to correspond with the "patient as a person" dissolves the very necessity of talking to the patient in the sense of exchanging recognitions about the "patient as a person" with the patient. I have argued further that Benner et al´s assertion that the nurse´s recognition of the "patient as a person" helps her to shape her "clinical judgment"(to know what is important in the situation of the patient) helps the nurse who adopts this position to create an almost total social distance to the patient.

I have also shown in Chapter Ten how the nurse´s assumption about the *nurses´* recognition in contrast to the *physicians´* recognition of the patient´s "quality of life" to correspond with the patient´s "quality of life", produces the physicians´ recognition of the patient´s "quality of life" as "distinctions" from the nurse´s perspective, thereby, effecting a social distance between nurses and physicians.

In Chapter Eleven I have discussed how, for Rubin (1996), the expert nurse assumes a ´correspondence´ and reveals this assumption in a "language of needs". This is, on Rubin´s analysis, in contrast to the experienced but *not* expert nurse, who apparently does *not* assume a ´correspondence´. The experienced but *not* expert nurse is seen to express her assumption in a "language of wants".

On Rubin´s analysis, I have taken the expert nurse to enact the assertion of Benner et al´s cognitive interpretation of the nurse´s recognition at the expert stage; that is, Benner et al´s ´solution´ to the

uncertainty of the advanced beginner nurse´s recognition informed by her theoretical knowledge from nursing school; and I have taken the experienced but *not* expert nurse to enact the claims of Orlando´s idea of "exploration" (non-cognitive and minimal cognitive interpretation of the nurse´s recognition).

I have drawn out the crucial difference between Orlando´s ´solution´ and Benner et al´s ´solution´ concerning the uncertainty of the nurse´s recognition of the patient´s situation: while the view of the former allows for an exchange of recognitions between nurse and patient in order to accomplish a correspondence about the situation of the patient as the precondition of an action decided upon "deliberatively"; the view of the latter makes an exchange of recognitions between nurse and patient about his or her situation unnecessary. In other words: Benner et al´s ´solution´, creates a social distance between nurse and patient; while Orlando´s ´solution´ offers the possibility of decreasing such distance.

Returning to *From Novice to Expert*

At the beginning of this thesis I quoted Benner et al who have stated the response of nurses around the world to *From Novice to Expertise*, that is, "to that account of gaining clinical expertise" (1996:XIII), that is, practical knowledge.

If one considers the nurses´ response in the light of *Expertise in Nursing Practice as* an extension of Benner´s (1984) first study and of its discussion in this thesis, then Benner et al are implying that nurses worldwide assume that their recognition of the situation of the patient in terms of theoretical knowledge they learn in nursing school is not corresponding with the situation of the patient.

If theories of knowledge are taken to be interpretations of the person´s recognition and if theorizing recognition has moved from a cognitive to a non-cognitive

interpretation, then nurses who are uncertain about their recognition of the situation of the patient as informed by their theoretical knowledge from nursing school would support the latter. Nurses who have been practicing critical care nursing for more than five years and who are still 'using' the "language of wants", that is, asking the patient to tell his "need" (Rubin, 1996) would be further supporting the claim of a non-cognitive interpretation of recognition. Even Benner et al cannot help but note "that experts made disclaimers about *'never'* being certain (1996:121; emphasis mine).

On the other hand, if the response of nurses "all over the world" to Benner's (1984) account of practical knowledge ("clinical expertise") is considered on Benner et al's (1996) conception about the nurse's recognition acquiring the ability to *read* the situation of the patient, which is to say, that her recognition at the proficient and expert stage is asserted to correspond with the situation *because* it is informed by her practical knowledge rather than her theoretical knowledge, then, these nurses adopt, on account of the discussion in this thesis, implicitly or explicitly, the view of a cognitive interpretation of recognition. This thesis has shown how the nurse's certainty about a correspondence between her recognition and the situation of the patient distances the patient from the nurse by excluding his recognition from the nurse's recognition.

Yet Orlando's (1961) idea of "exploration" offers a solution in that an exchange of recognitions between nurse and patient provides the possibility of decreasing a social distance between nurse and patient through the accomplishment of a correspondence about the situation of the patient in everyday work.

If one accepts Orlando's idea of an "exploration" as a condition of accomplishing a correspondence between nurse and patient, then Benner and her colleagues make, from my point of view, a substantial contribution to the discussion of such condition, since their work engages specifically with epistemological issues of the nurse's

recognition and differs, in this respect, from Orlando´s study.

Benner and her colleagues differ also from a nursing theorist like Johnson (Chapter Three) who is interested in *reformulating* "borrowed" theory *unique* to nursing. Instead, Benner and her colleagues utilize ´borrowed´ theory. For example, Benner (1984) draws on theories of knowledge, such as Heidegger´s and Gadamer´s, in order to point out that the nurse´s recognition informed by theoretical knowledge ("theory") is "challenged, refined, or disconfirmed by the actual situation" (1984:3), that is, not corresponding with the situation of the patient.

This is the reason which, to my understanding, justifies Kesselring´s (1997) statement about *From Novice to Expert* being a "milestone". According to Kesselring, it is considered as "one of the most important contributions to the philosophic scientific understanding of contemporary nursing" (my translation, I.V.). ("Das Werk gilt als einer der wichtigsten Beiträge zum philosophisch-wissenschaftlichen Verständnis der zeitgenössischen Krankenpflege" (Kesselring, 1997:11).

That Benner´s (1984) study constitutes a milestone in nursing theory has already been pointed out by Latimer (1993) in the context of discussing the methodology underpinning her research. Benner´s interpretation of nurses´ accounts, a "bottom down approach" of developing nursing knowledge, is seen to be a "radical shift from the normative top down approach to reforming clinical practice represented by models for nursing" (Latimer, 1993:311), that is, developing nursing knowledge in terms of conceptions of nursing.

But as Latimer already notes that Benner´s (1984) "position is a notion that nurses´ theoretical knowledge is enriched, enhanced and sometimes *transformed* through experience" (1993:312; emphasis mine), that is, through her recognition of situations of patients in her everyday work.

Since this 'transformation' of the nurse's theoretical knowledge into practical knowledge involves, as this thesis has shown at length, a cognitive interpretation of recognition, it can be said that Benner and her colleagues remain within the "normative top down" approach, if understood as the position of nursing theorists (Abdellah, 19960; Roy, 1984) who seem to think that the nurse's recognition informed by conceptions of nursing corresponds with the situation of the patient.

The work of Benner and her colleagues (1984, 1989, 1996) is an attempt, I suggest, of establishing "an alternative truth theory that *matches* the *appeal* of the correspondence theory of truth" (Benner et al, 1996:369; emphasis mine).

Yet in drawing, particularly on Heidegger, who in *Being and Time*, tries to go beyond the logocentric tradition in that he not any longer presupposes a cognitive principle for his interpretation of recognition, Benner and her colleagues provide the "philosophic-scientific" (Kesselring, 1997) contribution which challenges, as has been shown in this thesis, their own endeavour of establishing "an alternative truth theory" to "the correspondence theory of truth".

Outlook

Considering the utility of the thesis, it is necessary to return to Benner et al's notion that theories of knowledge are descriptions rather than interpretations.

Discussing this idea of Benner et al in Chapter Five (and in the following ones, particularly in Chapter Nine), I have pointed out that it involves an inversion of claims: instead of acknowledging the claim of a cognitive interpretation ("Cartesian view") about a correspondence between person and object, this view describes, for them, the advanced beginner nurse's recognition as based on her theoretical knowledge which is not corresponding with the situation of the patient; and in instead of accepting the claim about an uncertain (not corresponding) recognition,

following Heidegger's non-cognitive theory of knowledge, Benner et al advance the claim in connection with their conception (the nurse's development of "skills of seeing" and practical knowledge on the basis of the nurse's emotions and *caring*, the latter being derived from Heidegger) that the nurse's recognition at the proficient and expert stage is corresponding.

Inverting these claims means that Benner et al *misrepresent* the claims of cognitive and non-cognitive interpretations of recognition; that is, Benner et al misread theories of knowledge in as far as they take them to be descriptions rather than interpretations. The consequence of such misreading is the inversion of claims and subsequent re-constitution of a cognitive conception (Chapters Four to Seven) as the condition of making the assertion about the nurse's 'corresponding' recognition at particular stages of the Dreyfus Model of skill acquisition.

Unfortunately, Benner and her colleagues are not the only nurse theorists who misread Heidegger's non-cognitive theory of knowledge and thus remain within a cognitive (Cartesian) view of recognition. Paley surmises on his analysis of Heidegger in nursing literature - which does neither include the study of Benner (1984) nor of Benner et al (1996) - that "lived experience" research as carried out by nursing theorists, does not constitute "a realization, but rather a betrayal, of Heidegger's phenomenology, being thoroughly Cartesian in spirit" (1998:817).

Heidegger is, furthermore, not the only philosopher misinterpreted by nursing theorists. Paley shows in another paper how nursing theorists "largely misunderstand" Husserl's concepts, such as "phenomenological reduction, phenomena, and essence" and that as a result: "their version of Husserl's philosophy bears little resemblance to the original" (1997:187).

On this account, it is reasonable to expect that nursing theorists will also misread a conception such as

Derrida´s *différance* and are likely to draw implications from it for research as well as for teaching in nursing which comes, in Paley´s words, "close to being unintelligible" (1997:187).

At the same time, this thesis which reveals Benner et al´s particular misreading of theories of knowledge can be utilized to cultivate an open and constructive discussion - first and foremost - among nursing theorists about their reading of interpretations of recognition in general, about a move from cognitive to non-cognitive interpretations in particular, and about the consequences of the latter for research and teaching in nursing.

APPENDIX

PROBLEMATIZING A SCIENCE *UNIQUE* TO NURSING

Introduction

Johnson´s idea (1959a, 1959b, 1968, 1974) that a science (theory) unique to nursing is to be developed from a perspective of nursing on man rather than from a perspective of the biological and the behavioural sciences on man implies the possibility of generating a science unique to nursing.

I want to problematize such possibility in relation with Foucault´s (1970) theory of knowledge and Roy´s (1984) conception of nursing about the person as a "holistic adaptive system".

The Organizing Concepts of the Human Sciences

Munro (1994) notices that Foucault´s (1970) concern in *The Order of Things* is not only to explicate the emergence of the human sciences. Foucault is seen to also delineate the "closure" of the human sciences, psychology, sociology and cultural anthropology as affected through their organizing concepts (Munro, 1994:5). Foucault notes:

> Thus, these three pairs of *function* and *norm* , *conflict* and *rule* *signification* and *system* completely cover the entire domain of what can be known about man (Foucault, 1970:357; emphasis in the original).

In Foucault´s analysis these concepts are not limited to one discipline. For example, ´function´ and ´norm´ as the "formal" pair for knowing what is on the level of psychology analysis, revolves among the other disciplines:

> In this way all the human sciences interlock and can always be used to

> interpret one another (Foucault, 1970:358).

Munro suggests that this interlocking creates an effect of "completeness", leaving no space for "new" sciences (1994:5), since:

> Everything may be thought within the order of the system, the rule, and the norm. By pluralizing itself - since systems are isolated, since rules form closed wholes, since norms are posited in their autonomy - the field of the human sciences found itself unified: suddenly, it was no longer fissured along its former dichotomy of values (Foucault, 1970:360-361).

If the domain of the human sciences is already covered by the "epistemological regions" (Foucault, 1970:355) of psychology, sociology and cultural anthropology, then, at least on Foucault´s analysis, any "founding" (Foucault, 1970:358) of a theory (science) unique to nursing would have to be developed *within* those epistemological regions.

Ruling Apart

Despite an interlocking and a perpetual rotation of concepts, the human sciences "rule through their division" (Munro, 1994:6).

Their organizing concepts both "link together" and "hold apart" the positivities of life, labour, and language (Foucault, 1970:362; Munro, 1994). It is, according to Foucault:

> the choice of the fundamental model and the position of the secondary models, which make it possible to know at what point one begins to ´psychologize´ or ´sociologize´ in the study of literature and myth, or at what point in psychology one has moved over into the decipherment of texts or into sociological analysis (1970:358).

For Munro, "holding apart" of psychology, sociology, and cultural anthropology, the study of literature and myth, does not foreclose "multi-disciplinary" approaches as long as the concepts are kept "distinct" (1994:6). Foucault states:

> it proved possible to conduct an admirably precise study of the Indo-European mythologies by using the sociological model *superimposed* upon the basic analysis of significants and significations (1970:358; emphasis mine).

In contrast, the consequences of not ordering the human sciences precisely, that is, keeping them apart, are, for Foucault, a "disaster" (Munro, 1994:6).

> We know also, on the other hand, to what syncretic platitudes the still mediocre undertaking of *founding* a so-called ´clinical´ psychology has led (Foucault, 1970:358; emphasis mine).

The point emphasised by Munro on Foucault´s analysis is that the human sciences "rule through ruling each other apart" (1994:6). They have their "justification":

> in the play of oppositions, which makes it possible to define each of the three models in relation to the two others (Foucault, 1970:358).

Each discipline is defined in opposition to the others. The "negativity" of one is the "positivity" of the other (Munro, 1994:6).

The Human Sciences and the *episteme*

Another point Foucault makes about the human sciences is how they are distributed within the *episteme*. Foucault delineates the "domain" of the modern *episteme* as a "volume of space open in three dimensions" (1970:346-347). In his analysis the "mathematical and physical sciences" are situated in one dimension. The second dimension

locates the "empirical" (1970:348) sciences of "linguistics, biology, and economics" (1970:347). The third dimension is that of "philosophical reflection". Foucault notes that each of the dimension is linked with another dimension to define a "common plane" (1970:347). One 'common plane' combines the dimension of 'mathematical and physical sciences', which Foucault calls the "deductive" (1970:348) sciences and the dimension of 'empirical' sciences. The dimension of 'philosophical reflection' links with the dimensions of 'deductive' sciences and the 'empirical' sciences to form with each of the two dimensions a 'common plane' (1970:347).

The place of the human sciences, psychology, sociology, and cultural anthropology within this "three-dimensional-space" (1970:347) is one of being 'excluded' and 'included', since the human sciences are situated in the 'interstices' of these three 'knowledge branches':

> From this epistemological trihedron the human sciences are *excluded*, at least in the sense that they cannot be found along any of its dimensions or on the surface of any of the planes thus defined. But one can equally say that they are *included* in it, since it is in the *interstices* of these branches of knowledge, or, more exactly, in the volume defined by their three dimensions, that the human sciences have their place (Foucault, 1970:347; emphasis mine).

Foucault points out that this "situation" places the human sciences in "*relation* to all the other forms of knowledge" (1970:347; emphasis mine). The other point Foucault makes is that this 'relation' of the human sciences with the dimensions of the 'deductive' sciences, the 'empirical' sciences, and 'philosophical reflections' is one of "perpetual controversy" (1970:345). The former claim to be the "foundation" of the latter, while the latter:

> are ceaselessly obliged in turn to seek their own foundation, the justification of their method, and the purification of their history, in the teeth of

> 'psychologism', 'sociologism', and 'historicism' (Foucault, 1970:345-346).

This precarious relation gives the human sciences their "essential instability" (Foucault, 1970:348):

> we know what difficulties may be encountered, at times, in the establishing of those intermediary planes that link together the three dimensions of the epistemological space; for the slightest deviation from these rigorously defined planes sends thought tumbling over into the domain occupied by the human sciences (Foucault, 1970:348; emphasis mine).

Foucault notes that the disciplines of psychology, sociology, and cultural anthropology are "dangerous intermediaries" (1970:348) in the 'three-dimensional-space' of knowledge.

Concequence

If one considers, on this account, Roy's claim to develop a "nursing science perspective" of the person's "adaptive processes" (1984:31), then four possible consequences of a science unique to nursing can be pointed out.

One is that of repeating gestures already made. Despite Roy's claim to develop a "nursing science perspective" on the person's "adaptive processes", Roy draws, by naming, for example, 'organs, tissues, and neural stimuli' in order to construct the physiological processes of the regulator subsystem ("biological organism") on the empirical sciences; while she draws on disciplines such as psychology and sociology for the invention of the cognator subsystem by placing knowledge "currently" known about "human abilites" within four separate "cognitive/emotive" processes.

The implication being that her exploration, for example, of the regulator subsystem in terms of 'organs, tissue, and neural stimuli' requires the "epistemological

consciousness" (Foucault, 1970) of the empirical sciences in terms of disciplines, such as anatomy and physiology.

A second consequence of developing a science unique to nursing is to throw it into "confusion" (Foucault, 1970). Roy´s promise that a "developing nursing knowledge" will explore the *interrelationship* between the regulator ("biological organism") and cognator subsystems collapses the "rigourously defined planes" (Foucault, 1970), for example, between the empirical sciences and the human sciences.

A third consequence of developing a science unique to nursing is to establish "syncretic platitudes" (Foucault, 1970). As Munro (1994) points out, to keep the concepts of each discipline "distinct", the disciplines "rule through ruling each other apart". Such keeping "apart" leads to "multi disciplinary" (Munro, 1994) explorations. For example, the person´s adaptive processes of "avoidance of anxiety" may be explored by the discipline of psychology and its formal concepts of analysis; and by the discipline of sociology and its formal concepts of analysis; and by the discipline of cultural anthropology and its formal concepts of analysis.

If Roy claims that explorations of the interrelationship between the adaptive processes of the regulator and cognator subsystems increase the understanding of the holistic nature of the human person, then such understanding is achieved only by ruling those adaptive processes through multi-disciplinary explorations apart.

A fourth consequence follows from the foregoing ones. Since each discipline defines its formal concepts "in the teeth" (Foucault, 1970) of the other disciplines, the implication is one of "perpetual controversy" which encourages more explorations of the persons adaptive processes and thus produces an endless flow of current knowledge about "human abilities".

Since Roy places "current" knowledge about "human abilites" within four separate "cognitive/emotive"

processes of the persons cognator subsystem, a perpetual flow of ´current´ knowledge concerning "human abilites" implies a continuous process of updating her construct of the person as a holistic adaptive system which renders any understanding of the person as a holistic adaptive system an impossibility.

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